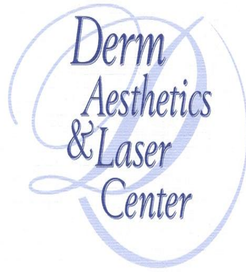

Credit Card Charge Authorization Agreement
Office Policy

Derm Aesthetics & Laser Center must have a current credit card on file to secure any consultation, appointment, and/or procedures as well as a valid drivers license.

We request the courtesy of a 48-hour advance notification on **all procedure** cancellations. All **consultations** require a 24-hour advance notice of cancellation. Appointments booked the same day of service will be assessed a no show fee should cancellation become necessary. For treatments that are pre-paid, the pre-paid treatment will be forfeited without 48-hour notice of cancellation. There are **NO REFUNDS** on Pre-payment of packages. Any pre-pricing on treatments are as stated at the time of scheduling.

In the event that our office is not notified as requested above for procedures, there will be a non-refundable cancellation fee of 20% of your procedure if less than $1000 and a fee of 50% of your procedure if greater than $1000. A $50 No-Show fee will be charged for cancellation of consultations. You can notify our office at 972-690-7070. If you call after office hours or on weekends please leave a detailed message with your name, number, time and date of your procedure as well as what you are having done, as this contacts a staff member on-call. This courtesy on your part will make it possible to give your appointment to another patient.
Thank you for your cooperation.

I, ____, the holder of

(Please circle one): VISA MASTERCARD AMEX DISCOVER
AMEX Auth# ____________

Card Number: _________________________________, Exp ______/ _______

hereby authorize Derm Aesthetics & Laser Center to charge my credit card in the amount for fees required for a No-Show of consultations and/or procedures in the policies stated above.

I have read this entire agreement and understand that I will be held fully responsible for its terms and charges. I agree not to chargeback Derm Aesthetics & Laser Center, as long as I receive the services agreed upon by consent verbally or written and office guidelines are followed for my rescheduling and cancellation of appointments.

Name on Card: ____

Signature: ____

Credit Card Billing Address: ____

City, State, and Zip: ____

Telephone: (____) ___________________________

Date: ___________/_________/__________________