LYLE PLASTIC SURGERY
& Aesthetics Center

Patient Financial Responsibility Agreement

THIS ACCOUNT IS SELF-PAY, POINT OF SALE AND PAYMENT IN FULL IS DUE AT THE TIME OF EACH SERVICE.

I clearly understand and agree that all services rendered to me by Lyle Plastic Surgery and Aesthetics Center, PLLC ("**Practice**") will be charged directly to me and that I am personally responsible for full payment to Practice. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that I am responsible for any outstanding fees for services provided to me by Practice.

Any other arrangements that may involve a payment plan or payment deferral must be made in writing with the Office Manager of the Practice. Verbal agreements are not acceptable.

NO SHOW OR LATE POLICY

*I acknowledge that the Practice reserves the right to charge a fee of **$50.00** if I do not attend a scheduled appointment or cancel a scheduled appointment without providing at least 24 hours' prior notice to Practice, other than in an emergency. I further acknowledge the Practice reserves the right to reschedule my appointment if I am more than **15 minutes** late to a scheduled appointment.*

Printed Patient Name **Date**	**Signature of Patient**
Practice Representative Name	**Signature of Practice Representative**