



THE NEW YORK  
AESTHETIC CONSULTANTS  
PLASTIC, LASER & DERMASURGERY

DERMASURGERY

RON M. SHELTON, M.D., F.A.A.D.

PLASTIC SURGERY

TED CHAGLASSIAN, M.D., F.A.C.S.  
WILFRED BROWN, M.D., F.A.C.S.

NEW YORK OFFICE-BASED SURGERY, PLLC



Accredited by the Joint Commission

**Financial Policy for Non-Surgical Procedures**

- The balance of the procedure fee must be paid at least 2 weeks prior to the procedure date.
- The consultation fee of \$150 will be waived for any procedure over \$500 that is paid in full on day of the consultation, or it will be applied towards a procedure that is performed within 3 months after the consultation.
- Procedure fee quotes are valid for 3 months and include all pre- and post-procedure visits.
- A non-refundable deposit of \$500 is required for any procedure over \$2,000 on the day a procedure is scheduled. If your procedure date needs to be rescheduled due to an emergency, this deposit will be reapplied towards a new procedure date. A procedure that is rescheduled more than once will require an additional non-refundable deposit of \$500.
- The NYAC accepts payment by cash, bank check, MasterCard, Visa, Discover, American Express, or financing through CareCredit. Bank checks must be made payable to The New York Aesthetic Consultants. Personal checks are not accepted.
- If you cancel the procedure within 2 weeks of the scheduled procedure date, 25% of the Physician's fee and the \$500 deposit will be retained by the NYAC. If you cancel the procedure within a week or less of the scheduled procedure date, 50% of the Physician's fee and the \$500 deposit will be retained by the NYAC.
- All refunds must be approved by the NYAC Practice Administrator. Refunds will be made 30 days from date of the request. In the event of a refund request for a payment made by credit card, a deduction of 5% will be retained by the NYAC.

Mastercard \_\_\_\_\_ Visa \_\_\_\_\_ American Express \_\_\_\_\_ Discover \_\_\_\_\_

Card # \_\_\_\_\_

Exp \_\_\_\_\_ / \_\_\_\_\_ Security ID # (3-4 digits, on back of card) \_\_\_\_\_

Card Holder \_\_\_\_\_

**I hereby authorize The NYAC to charge my credit card and hereby confirm I will not dispute this charge with my credit card company. Signature \_\_\_\_\_**

*By signing below, I acknowledge I have read and agree to the above policy terms and conditions.*

Patient Name: \_\_\_\_\_

Patient/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_