STX SOUTH TEXAS DERM DERMATOLOGY

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GENERAL COSMETIC SERVICES CONSENT, FINANCIAL AGREEMENT & NOTICE OF NON-COVERED SERVICE

Cosmetic Treatment Consent

I understand that I am receiving cosmetic services through South Texas Dermatology. Cosmetic services may include, but are not limited to, aesthetic consultations, injectables, fillers, neurotoxins, laser treatments, chemical peels, skin care treatments, cosmetic procedures, or other elective aesthetic services recommended or performed by the provider, practitioner, or cosmetic department.

I understand that cosmetic treatments are elective and are performed to help improve appearance based on my personal aesthetic goals. I understand that results may vary from patient to patient and that no specific outcome or final result can be guaranteed.

Prior to receiving treatment, I have communicated with the practitioner about any conditions, medications, or medical history that may contraindicate this procedure.

I understand that patients may not be candidates for certain cosmetic treatments if they:

- have used oral isotretinoin, including Accutane, within the past 6 months;
- have active cold sores, warts, open wounds, or a history of herpes simplex;
- are undergoing chemotherapy and/or radiation therapy within 6 months;
- have a history of autoimmune disease, including Lupus, liver disease/disorder, or any condition that may weaken the immune system.

I understand that there may be some degree of discomfort during and after cosmetic treatment, including but not limited to burning, stinging, redness, heat, tightness, tenderness, swelling, bruising, irritation, or sensitivity.

I understand that there is no guarantee of the final results of any cosmetic procedure. I understand that hyperpigmentation or other skin changes may occasionally develop and may persist for a week or months after treatment.

I understand that although complications are rare, they may occur. In the event of any complications, concerns, or unexpected reactions, I will immediately contact the physician, clinician, practitioner, or cosmetic department.

I understand that if I have acne or acne-prone skin, cosmetic procedures may bring oils and bacteria from below the surface and may cause an actual breakout.

I understand that maintenance of cosmetic procedures may be necessary to maintain results, along with the recommended skin care regimen and SPF 50+ as discussed with me by the cosmetic consultant, practitioner, or provider.

I understand that extended direct sun exposure, including tanning beds, is strictly prohibited before and after receiving cosmetic treatments unless otherwise directed by the provider or practitioner.

I understand that this is an elective cosmetic procedure.

Notice of Non-Covered Service

I understand that the services identified as cosmetic are not a covered benefit under my insurance plan.

My initials and signature signify that I understand the services identified above are not covered by insurance. My decision to have this procedure rendered and my signature indicate that the procedure is strictly for cosmetic purposes, is not medically necessary, and therefore should not and will not be submitted to my insurance plan for payment.

I understand that South Texas Dermatology will at no time, now or in the future, submit a claim to my insurance carrier as the provider has deemed the service to be not medically necessary under the terms of this practice's contract with my insurance carrier.

I understand that I am responsible for all charges as out-of-pocket expenses and will not be reimbursed by my insurance plan.

Self-Pay & Payment Due at Time of Service

I understand that all cosmetic services, products, packages, pre-purchased treatments, and elective cosmetic procedures are self-pay.

I understand that payment is due in full at the time of service. Treatment may not be performed if payment has not been made.

I understand that I am responsible for payment in full at the conclusion of the visit and accept all cosmetic charges as out-of-pocket expenses.

No Refund Policy

I understand and agree that there are no refunds for cosmetic services, cosmetic procedures, packages, pre-purchased treatments, deposits, promotional purchases, or cosmetic products.

I understand that dissatisfaction with results, changes in personal preference, missed appointments, unused treatments, or failure to complete a package within the required timeframe does not qualify for a refund.

Packages & Pre-Purchased Treatments

I understand that all cosmetic packages and pre-purchased treatments must be used within one year from the date of purchase.

I understand that any unused treatments, credits, packages, or pre-purchased services may expire after one year and will not be refunded, transferred, or exchanged unless otherwise approved in writing by management.

Appointment Cancellation / No-Show Policy

I understand that a $50 no-show or late cancellation fee may be charged if I fail to attend my scheduled cosmetic appointment or cancel without proper notice according to South Texas Dermatology's scheduling policy.

I understand that repeated missed appointments or late cancellations may affect my ability to schedule future cosmetic services.

Cosmetic Concerns & Questions

For cosmetic concerns, questions, scheduling, or follow-up needs, I understand that I should contact South Texas Dermatology at: 361-882-8169

Patient Acknowledgment

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement in its entirety. All of my questions have been answered to my satisfaction, and I consent to the terms of this agreement.

Alternative methods of treatment and their risks and benefits have been explained to me. I understand that I have the right to refuse treatment.

By signing below, I confirm that I understand cosmetic services are elective, self-pay, not covered by insurance, non-refundable, and payment is due at the time of service. I also understand that I am responsible for following all pre-treatment and post-treatment instructions provided by South Texas Dermatology.

Name: _____

Date: _____

Signature: _____