

KAMBIZ TAJKARIMI MD

AESTHETICS & ANTI-AGING MEDICINE & SURGERY
ALIA - ADVANCED LASER INSTITUTE OF AMERICA

Payment Options: Direct ACH Transfer (Preferred), Credit Card (Amex, Visa, MC, Discover), United Medical Financing, Care Credit, Care Cap.

ACH Transfer Information:

Bank Name: Truist

Account Number: ADVANCED LASER INSTITUTE OF AMERICA

ACCOUNT NUMBER: 1470001305921

ROUTING NUMBER: 051404260

Office Address: 44055 Riverside Parkway, Suite 208, Leesburg, VA 20176

Credit Card Processing Form:

Please complete all fields

Cardholder's Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____ CVV: _____

I, _____, authorize Advanced Laser Institute of America to charge my credit card above for the agreed amount of _____ .

Patient Signature

CANCELLATION AND PAYMENT POLICY

We are excited that you have decided to proceed with your procedure(s). By placing a deposit, you are securing a date for your procedure and agreeing to the following terms below. Because of the advanced preparation and resources required to ensure a positive experience for every patient, our clinic has the following policies. These policies are designed to ensure a seamless, efficient process for you. Please let us know if you have any questions.

The Surgery Price That You Were Quoted Covers: Anesthesia Fee, Surgery Center Fee, Surgeon Fee, Implants(Penuma), Pre- and Post-Operative Visits, and Some Necessary Garments.

The Quote Does Not Cover: Travel, Accommodation, Transportation, Medications, Pre-Operative Clearance, Labs, Aftercare Stay, and Other Extra Garments.

For Penuma, we require a \$2500 deposit. For liposuction and all other procedures, we require a 50% deposit at the time of scheduling, unless choosing to finance.

By placing a deposit towards your procedure, you agree to the following terms: Cancellation Policy: We understand that due to unexpected circumstances, you may need to cancel the scheduled surgery. If you, the patient, for any reason cancel your procedure there will be a \$2,500 administrative /surgery center fee charged and withheld from your deposit with any balance refunded. If a patient is a no-show on the day of surgery without prior notice or if a patient decides to cancel the surgery the day of the surgery, the patient's deposit will be forfeited, and the patient will be assessed an additional \$1,000 administrative fee. Case-by-case exceptions may be made for medical reasons at the sole and absolute discretion of the clinic. If a patient has not completed full payment by the day of the surgery, the surgery will be canceled, the deposit will be forfeited, and a \$3000 administrative fee will be assessed. I hereby acknowledge that any balance refunded will be sent to me, the patient, by check or credit card. We require payment in full 3 weeks prior to surgery.

Rescheduling Policy: Everyone's time is valuable. When you reschedule your surgery, not only does it affect you, but also the staff at the surgery center, the surgeon, and other patients. We request you reschedule only if it is absolutely necessary. Reschedule requests must be done via email to your patient consultant at least 2 weeks (14 days) prior to your procedure date. You may reschedule your procedure date up to two times for documented medical reasons or other extenuating circumstances, and again, any reschedule requests must be received by your consultant by email. If you reschedule 7 days or less prior to your surgery, there will be a \$1000 rescheduling fee.

Initials

Payment Options: We accept Cashier's check, Wire Transfer, VISA, MC, AMEX, and DISCOVER. We do not accept cash. We also offer financing through third-party lenders. By placing a deposit towards your procedure, you agree to the following statements: You have discussed the possible risks, complications, and alternatives, including no surgery, and I have had an opportunity to discuss all the questions you have.

You acknowledge that you are required to have a competent adult (e.g., spouse, close friend) with me at the surgery center on the date of my procedure and for at least 24 hours after the procedure. If you do not have a competent adult with you, you must inform the clinic in advance, so the clinic/surgery center can suggest caretaker options at an additional cost to me.

All discharge instructions will be discussed with the competent adult and me during admission. You have been offered an opportunity to do an in-person or phone consultation with the medical staff well in advance of any procedures. You have been encouraged and offered an opportunity to seek therapy/counseling sessions before the procedure(s). You understand that you have to obtain the required Pre-Operative Clearance, Labs, and medication. Failure to provide the requested document to the clinic prior to the procedure date will result in cancelation of the procedure and forfeiture of the deposit.

Patient Name

Date

Patient Signature