DOWNSIZE!

TUMESCENT LIPO SERVICE AGREEMENT

Patient agrees to purchase Tumescent Lipo And Downsize agrees to provide such services to the patient according to the following terms and conditions:

Purchase of Services:_____agrees to purchase the following_____area(s)(please initial)

Abs(Upper/Lower)____	Flanks____	Hips____	Thighs(Inner/Outer)____	Axilla____
Sub Bra Strap ____	Chin ____	Arms____	Back(Upper/Lower)____	Chest____
Knees(Inner/Top) ____	360(U/L/F/Sub Bra) ____		Thighs(Front/Back)____	Supra Pubic ___

Area(s) Quote: $_____
Garment & Binder $_____
For a Total Fee of $_____

Date/Amount Paid:____/____/____$_____
Date/Amount Paid:____/____/____$_____
Date/Amount Paid:____/____/____$_____
Date/Amount Paid:____/____/____$_____

_____Downsize has already collected cash or charged my credit card per these terms and will not Recharge me.

_____Downsize has already charged my LendingUsa/Advance care card/Prosper Healthcare per these terms and will not recharge me.

_____Downsize is authorized to charge my credit card per these terms.

_____VISA _____AMEX _____MASTERCARD _____DISCOVER

CC#_____Expiration:_____/_____

Security Code (number on back of Visa or MC or on front of AMEX):_____

Non-Refundable-Patient understand and agrees this is a binding agreement and that fees paid for all Lipo Procedures are Non-Refundable. I understand that if I decide to have further treatments this consent continues for all subsequent procedures regardless of the time between treatments.

Cancellation Policy-In the event a scheduled procedure must be rescheduled or canceled,10 business days notice is required.This may be accomplished by calling 832-955-1221. In the event the required notice is not given,you will be assessed $1000. fee.The $1000 deposit is not refundable.If you fail to return your three prescriptions,then you will not receive a refund.

Customer Service-All customer service requests or needs shall be addressed by submitting said request in Writing.

A customer service representative will investigate the request or need and respond.

Full payment is required 7 days before the procedure.

By placing my signature, I certify that I have read, or have read to me the contents of this form. Further, my signature indicates that I understand the information presented above and have had all of my questions were answered to my complete satisfaction.

Patient Signature

_____
Signature Date

Physician/Staff Signature

_____
Signature Date