

**LASER, AESTHETICS, AND BODY INSTITUTE**  
**Patient Agreement**

**DR. JARED JAGDEO**

PATIENT NAME:

DATE OF SERVICE:

REFERRING PHYSICIAN:

MEDICAL RECORD:

GUARANTOR NAME:

SERIAL NO:

PROCEDURES	CPT	UNITS	PRICE
Cosmetic Consultation	99202	per Session	\$ 99
Light Facial	17999*	per Session	\$ 199
Chemical Peel	17999*	per Session	\$ 250
Platelet-Rich plasma Injection (PRP) - Hair or Facial Injection	99203	per Session	\$ 900
CO2 Laser Resurfacing Treatment - Face	96999*	per Session	\$ 1,000
Radiofrequency (RF) Therapy - Face	17999*	per Session	\$ 750
Tattoo Removal - Small Area	17999*	per Tattoo	\$ 250
Tattoo Removal - Large Area	17999*	per Tattoo	\$ 450
Intense Pulsed Light (IPL) - Face	96999*	per Session	\$ 450
Wrinkle Relaxer (Botox or Similar)	17999*	per area	\$ 350
Fillers	17108	per 1 cc Syringe	\$ 800
Single Lesion Removal	17999*	per Session	\$ 650
Vascular Blood Vessel Removal	17999*	per Session	\$ 250
Scar Treatment with Fractionated CO2 - Small	17999*	per Session	\$ 450
Scar Treatment with Fractionated CO2 - Large	17999*	per Session	\$ 1,000
Laser Hair Removal - Small Area (Lip, Chin, Underarm, etc.)	17999*	per Session	\$ 325
Laser Hair Removal - Large Area (Legs, Back, Chest, etc.)	17999*	per Session	\$ 600

**Total Cost:**

You are being provided this patient agreement letter as you have agreed to pay for the services indicated above. Please review the information listed below and sign.

- A self-pay rate is offered to me as these procedures are deemed cosmetic and not covered by my insurance.
- The payment must be paid in full on the date of service and no claim will be submitted to my insurance carrier.
- The self-pay amount covers only the professional services provided by your physician. You are financially responsible for all ancillary services, for example laboratory, x-ray or other services not performed by your physician. You will receive a separate bill from the for those non-physician services.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative.

Patient/Guarantor's Name: \_\_\_\_\_

Patient/Guarantor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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