DOWNSTATE HEALTH

We Care.

Welcoming to All
Equity
Collaboration
Accountability
Respect
Excellence

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 C02 - Small	**17999***	per Session	$ 450
	Scar Treatment with Fractionated C02 - 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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