**Payment for Gold Program Services**

Cash Fee Services (these prices are per visit/and amount totaled)

gold Program members get 15% off of regular price packages, services & or bundles

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| ***Silver Program 10% Discount*** |
| **Service Type** | **Regular Price** | **Savings** | **You Pay** |
| New Patient Family Practice Visit | $130 | -20 | $110 |
| Return Patient Family Practice Visit | $95 | -15 | $80 |
| Sport/Scout Physical  | $30 | -5 | $25 |
| Initial weight loss appointment  | $140 | -21 | $119 |
| Return weight loss appointment | $105 | -16 | $89 |
| Initial Medical Cannabis Card | $265 | -40 | $225 |
| Return Medical Cannabis Card | $160 | -24 | $136 |
| Neuromodulators (Botox, Xeomin, Jauveau) (Dysport is $12 for 3 units which is 1 unit of the other NM) | $10.5 unit | -1.50  | $9u  |
| Filler 1/2 syringe  | $365 | -55 | $310 |
| Filler full Syringe  | $685 | -103 | $582 |
| Tear Troughs with Filler | $630 | -90 | $540 |
| Tear troughs with PRF | $710 | -107 | $603 |
| Tear Troughs with Filler and PRF | $815 | -123 | $692 |
| Tear Troughs with PDO threads | $630 | -90 | $540 |
| Micro Needling 1 area | $315 | -48 | $267 |
| Micro Needling with PRF 1 area | $525 | -79 | $446 |
| Each additional area Micro Needling | $160 each area | -24 | $136 |
| Each additional area Micro Needling with PRF | $210 each area | -32 | $178 |
| Lippo Dissolve (2-4 visits needed) | $525 each area/ each visit  | -79 | $446 |
| O Shot | $525 | -79 | $446 |

These are examples of what the discount looks like, with the increase cost of goods for these treatments' prices may change without written notification. Fees, may vary depending on delinquency of payment. *Payments are to be made at the beginning of this contract and then the same day each month for the next 5 months.* Cash, and most major credit cards are accepted. NO CHECKS ACCEPTED.

**Aesthetic & off label procedures are CASH ONLY PROCEDURES & payment is due at the time of service.**

**THERE ARE NO REFUNDS!**

**IF THERE IS A SPECIAL RUNNING AND YOU USE 1 OR MORE OF THE PROCEDURES, THERE IS NO REFUND FOR THE SERVICE.**

**Acknowledgement of financial responsibility and payment for services:**

**Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**