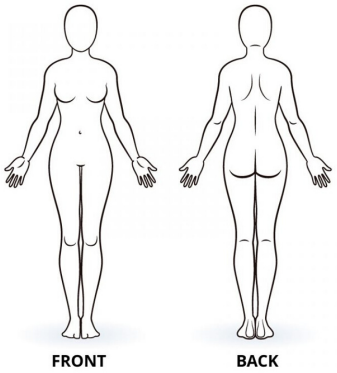
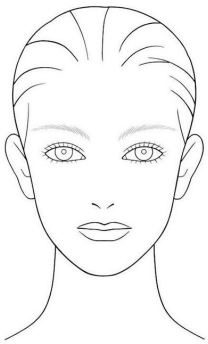
EVENT PRICE QUOTE

PATIENT NAME: _____ **DATE:** _____

PROVIDER: _____ **CONSULTANT:** _____





Service Type	Treatment Area	Regular Price	Discount	Event Price
Total Due				

Notes:_____

Deposit Policy to Confirm:In order to receive event pricing you must pay a $500 deposit.Procedure must be scheduled within 9 months of initial consult.By providing this deposit, I agree to these terms: The virtual event deposit is Non-Refundable but can be transferrable to other services we offer.

_____ _____

Patient Signature **Date**

Deposit Amount:_____ ◯ Credit Card ◯ Cash ◯ Check ◯ Prepaid ◯ GC

Balance Due: _____ Care Credit Number: _____

Treatment Date: _____