

## NON-REFUNDABLE DEPOSIT AGREEMENT

By my signature below, I \_\_\_\_\_ acknowledge that I am fully aware that my deposit of \$\_\_\_\_\_ toward my laser procedure is non-refundable. Further, I understand and agree that if I cancel my appointment, for any reason, my deposit is forfeited.

If making deposit by check, I waive the right to stop payment on this check.  
If making deposit by credit card, I waive the right to cancel this credit transaction.

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_ am/pm

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Witness*

\_\_\_\_\_  
*Date*

Payment Received: \$\_\_\_\_\_ Check# \_\_\_\_\_ / Cash

Credit Card (*MasterCard/Visa*)#:

\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_- Exp.Date: \_\_\_\_\_

Cardholder Name: \_\_\_\_\_