Quincy Plastic Surgery & Aesthetics

Welcome to the office of Paige C. Holt, MD & Glori Traeder, APRN.
Please take this time to become acquainted with the policies of our practice. You are at the core of all that we do. Our goal is to provide you with exceptional care each and every visit. In order to maintain our goal, we have highly trained staff available to help answer any questions you may have.

In our desire to be effective and fair to our employees and patients, please honor the following policies:

Appointment Policy: All non-surgical appointments must be secured with a credit card. Our highly-skilled team plan their appointment times to provide each client with expert care and undivided, unhurried attention. We ask that you kindly give us 24 hours notice to cancel or reschedule an appointment.

> *If you are unable to give us advance notice or you miss your appointment. We reserve the right to charge a "no show" cancellation fee of $75. This will result in the temporary suspension of services until the fee has been paid. To schedule a future appointment after a no show, a $75 deposit will be required to secure appointments.*

Of course, we understand that unanticipated events happen occasionally. Please contact us if you believe there was an error. By scheduling an appointment, you agree to our appointment policy. If you don't fall within our policy guidelines, your credit card will be charged.

Late arrival: Arriving late to an appointment may result in a shortened session to accommodate scheduled appointments thereafter. *Depending upon how late you arrive, the appointment may have to be rescheduled.*

Financial Policy: All professional services and products are charged directly to the patient. The patient is responsible for fees. **IMPORTANT: Checks are not accepted for products and nonsurgical services.** Cash, all major credit cards, Care Credit and Alphaeon Financing are accepted. Please contact us for more information.

I have read to the above policy and agree to comply with its provisions. I understand that I am responsible for payment for all services rendered. I understand that if I am covered by a third party payment service, such as Care Credit, I am personally responsible for such charges until they are paid in full.

_____

Signature *(Patient or Parent/Guardian if patient is under 18)* Date

707 N 24th St | Quincy IL | 62301
Phone: (217) 214-8282 | Fax: (217) 214-8200