



## WAIVER OF INSURANCE COVERAGE

I understand my treatment:

Is considered cosmetic in nature and as such it is not covered by my health insurance. As such, I will not submit any claim to my insurance company nor will Dr. Falconer's office.

I understand payment in full is required at the time of service. No money back guarantees or refunds will apply to any services rendered.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

