

Patient name: \_\_\_\_\_ Account number: \_\_\_\_\_ (for office staff)



## The Lotus Effect Membership Contract

1. **APPLICATION.** I am applying for membership in The Lotus Effect membership program at Bellaire Dermatology. The program set forth requires a 6- or 12-month commitment by the patient whether the membership is utilized or not. I represent and guarantee that proper consent for treatment and all facts and information set forth in the Membership Application are true, correct, and complete.
2. **PAYMENT.** (*Select Option*)  
\_\_\_\_\_ **Monthly Payment.** I agree to pay my monthly committed amount of **\$175** on the 1<sup>st</sup> of each month starting \_\_\_\_\_ thereafter through automatic withdrawal from an account I maintain in a financial institution pursuant to this signed authorization form. If I change financial institutions, I will provide Bellaire Dermatology in writing all information needed for the replacement automatic withdrawal at least ten (10) days before the effective date of the change. I agree to the monthly membership fee and acknowledge that the automatic withdrawal (payments) will continue for \_\_\_\_ 6 months or \_\_\_\_ 12 months period unless I terminate my membership as permitted in this Contract or I convert to another payment option with the consent of Bellaire Dermatology pursuant to a written contract. If I fail to make payment without notification to Bellaire Dermatology, Bellaire Dermatology will have full discretion for unpaid accounts and can take necessary actions to collect any unpaid balances for membership on services provided.
3. **TERM.** All memberships are charged on a month-to-month basis from the date of the Start Date and will annually auto renew.
4. **BENEFITS OF MEMBERSHIP.**
  - a. Access to personal Cosmetic Concierge team for easy scheduling and members needs
  - b. Receive a \$50 gift card to invite a friend to our practice (*new patients only*)
  - c. Receive one complimentary service per month with any of our available Aestheticians (cannot be restricted by patient for preferred Aesthetician availability)
    - i. Acleara
    - ii. Cooltone
    - iii. Custom Chemical Peel (TCA, SC MicroPeels)
    - iv. Dermaplaning MicroPeel
    - v. Diamond Glow
    - vi. HydraFacial
    - vii. Lotus Facial
    - viii. Laser Hair Removal (small area – under arms, lip, chin)
    - ix. Microdermabrasion
    - x. Spot IPL
  - d. Discounts off selected services:
    - i. 10% off Botox/Dysport
    - ii. 10% off Laser treatments not included in membership
    - iii. 15% off Skin Care Products
    - iv. 15% off CoolSculpting Elite Treatments
    - v. 15% off Chemical Peels not included in membership
  - e. Exclusive multi-Syringe discount, *starting at the first syringe:*
    - i. 1<sup>st</sup> syringe 10% off
    - ii. 2<sup>nd</sup> syringe 15% off
    - iii. 3<sup>rd</sup> syringe 20% off

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- f. Lotus Elite Treatments
    - i. In replacement of complimentary services listed in 4.c.
    - ii. Additional charge assessed for designated procedures (listed on brochure dated 03/07/2022)
  - g. Bellaire Dermatology reserves the right to change Benefits of Membership presently enforced or in the future prescribed by posting notice at least (30) days in advance of change.
5. CANCELLATION.
- a. Cancellation of this membership requires thirty (30) days of advance notice
    - i. All set-term payments shall survive the cancellation or termination of this contract.
  - b. Bellaire Dermatology reserves the right to revoke or suspend this membership for cause if I fail to keep the rules of this Contract. There are no refunds for membership fees, and Bellaire Dermatology will not prorate a cancelled membership.
6. NON-REFUNDABLE/TRANSFERABILITY OF PROGRAM.
- a. Monthly membership fees, along with complimentary services provided as a benefit of the membership, are non-refundable even if unused. No rollover of missed complimentary services are allowed. Only one rollover will be allowed and shall take place at the end of the term commitment.
  - b. For further explanation of these program requirements, please discuss with our staff.

_____	_____
Patient Name	Date of Birth
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Signature	Date

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