Dr. André Nel
THE HAIR, SKIN & WELLNESS
Clinic

Hair Restoration Procedure Agreement
Consent Form

I acknowledge that Dr. Andre Bel has educated me on the hair restoration surgical procedure I am aware that the charges for the procedure are as follows and that the full balance must be paid prior to the start of the procedure:

Number of Grafts/Follicular Units: _____
Total Procedure Cost: _____
Less Deposit Paid: _____
Balance: _____

Follow up visits that the acceptable forms of payment prior to the start of the procedure are: cash, bank draft (made payable to SMS Locums LTD). Debit & Credit Cards may be only on Dr Nel's own website **www.hair-skin-wellness.com**, scroll down to the bottom right & follow the instructions

Bank Details for Wire Transfer

Account Name: Specialist Medical Service Locums LTD,
Bank: Bank of Ireland, Cranford Centre, Stillorgan Road, Montrose, Co. Dublin
Sort Code: 901351
Account: 69561367
IBAN: IE30BOFI90135169561367
BIC: BOFIIE2D

Pateint Innitials: _____

Cancellation policy

I am aware that should I cancel the scheduled procedure 14 or more days prior to the procedure date, SMS locums LTD will refund my deposit in full. I am aware that if I cancel the scheduled procedure within 14 days of the scheduled procedure dfor any reason, it will be left to the discretion of the Surgeon to decide whether the deposit will be forfeited or refunded partially or in full.

Pateint's signature: _____ Prcedure Date/Time: _____

Print patient's name: _____ Prcedure Location: _____

Deposit Amount Collected: _____ Deposit payment type: _____