Pre-Surgical Payment & Cancellation Agreement

I, the undersigned, understand and agree that a deposit of $_____ is required to schedule and reserve my surgical procedure at North Toronto Eye Care/North Toronto Eye Surgery Centre. This deposit will be applied toward the total cost of the procedure.

I acknowledge the following terms regarding the deposit:

1. **Refund Policy:**
   The deposit is **refundable** under the following conditions:
   a. A **full refund** will be issued if the procedure is canceled **more than 20 business days** prior to the scheduled date.
   b. A **partial refund** (50%) will be issued if the procedure is canceled **between 10 and 20 business days** before the scheduled date.
   c. **No refund** will be issued if the procedure is canceled **within 10 business days** of the scheduled date, unless cancellation is due to a verified medical emergency or unforeseen circumstance, as determined by North Toronto Eye Care/North Toronto Eye Surgery Centre management.
   d. **If the procedure is canceled by North Toronto Eye Care/North Toronto Eye Surgery Centre due to internal reasons or clinic error**, a **full refund** of the deposit will be issued to the patient.
2. **Rescheduling:**
   Requests to reschedule must be made **at least 10 business days** in advance. If rescheduled within this timeframe, the deposit will be applied to the new date. Only **one rescheduling** is permitted without penalty. Additional changes may result in forfeiture of the deposit.
3. **No-Show Policy:**
   Failure to appear for the scheduled procedure without prior notice will result in the **forfeiture** of the deposit.
4. **Force Majeure:**
   In cases of unavoidable or unforeseeable events (e.g., natural disasters, public health emergencies, or government restrictions), North Toronto Eye Care/North Toronto Eye Surgery Centre reserves the right to reschedule the procedure or refund deposits at its sole discretion.
5. **Application of Deposit:**
   The deposit will be applied toward the total cost of the procedure. The remaining balance is due **prior to or on the day of surgery**, unless other arrangements are made in writing.
6. **Payment Methods:**
   Deposits may be paid by **Cash, Mastercard, Visa and/or Debit, Personal checks, EMT** and **AMEX** are **not accepted.** A receipt will be provided upon payment.
7. **Refund Processing:**
   If a refund is approved:
   a. Please allow **7 to 14 business days** for processing.
   b. Refunds will be issued to the **original method of payment**, **except in the case of cash and debit card payments**, which will be **refunded by cheque** due to processing limitations.
   c. Patients will be notified when the refund has been processed and when to expect it by mail or pickup.
8. **Acknowledgment:**
   I have read, understood, and agree to all terms outlined in this Surgical Deposit Agreement. I understand that failure to comply with these terms may result in forfeiture of the deposit.

Patient/Guardian Name (Printed): _____
Signature: _____
Date: _____