Graper • Harper
Cosmetic Surgery

Robert Graper, MD FACS • **Garrett Harper**, MD

Cancellation Policy/No Show Policy
We understand that things can come up unexpectedly. We value your time and in turn, know that you value ours. If you need to cancel your appointment, please be sure to notify us 24 hours prior to your appointment time. If we do not receive notice from you of cancellation or of need to re-schedule within a 24-hour time frame, we will charge a $50 - $100 cancellation/no show fee based on the length of your appointment. If you do not show up for your appointment without notification to cancel or re-schedule that appointment, that appointment will be marked as a No Show. If you "No Show" two or more times in a 12-month period, you will be subject to a $100 deposit before scheduling any future appointments.

This policy helps us keep our schedules running smoothly so that we can serve all of our patients in a timely manner.

Latecomer Policy
Please be sure to arrive on time for your scheduled appointment. Any late arrivals of more than 10-15 minutes may result in a re-scheduled appointment. This helps us stay on time to serve all our patients and dedicate the time that is needed to provide the best level of care to everyone.

Child Policy
Due to the many medical devices and objects used during treatments, we do not recommend children accompany you during your appointment. Please schedule your skincare and injectable appointments when it is convenient for you to have childcare, if needed.

Product Return Policy
All product sales are final. However, if you notice a defect in the product itself or the packaging, we will replace the product within 2 weeks of the product purchase date.

Contact Us
You may contact our office regarding your appointment by calling 704 375 7111 or replying to the email or text you receive requesting a confirmation of your appointment. If you have any questions regarding these policies and procedures, please let our staff know and we will be happy to address your concerns. We believe excellent provider/patient relationship is based on understanding and good communication and we are here to help you!

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I certify I have read and understand the Cancellation & No-Show Policy of the practice. I also understand and agree that such terms may be amended from time-to-time by the practice with notification.

I understand my credit card information will be saved under my 'Customer Profile' and I authorize that my card will be charged based on the above policy.

Patient Name_____Date_____

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