Advanced Medical Spa and Laser Center

CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: ____/____/_____

Consent for Treatment: I, The above named and undersigned patient, give my consent for care at and by the medical, nursing allied professional staff of advanced Medical Spa & Laser Center, which may include routine diagnostic procedures, cosmetic procedures and such medical treatment as my doctor or his/her designees may find are needed. I acknowledge that no promises or guarantees have been made to me about the results of any examinations, treatment or procedures that I may receive. I understand and acknowledge that full payment is due at the time services are rendered and that some services require a deposit in advance.

Release of Medical Records: I authorize Advanced Medical Spa & Laser Center to release all or any part of my medical record to (A) hospitals or medical service companies, insurance companies or agencies that may be concerned with the payment costs related to my treatment and (B) any other organization or agency to which the spa is permitted to release such information under applicable laws. In the event that I may be transferred or admitted to a hospital post-procedurally, I authorize the spa to obtain a copy of the hospital discharge summary.

Financial Agreement: I agree to the financial policies of Advanced Medical Spa & Laser Center in that I agree to uphold the cancellation policy for 24 hours' notice as a new client and existing client. I agree as a new patient, If I do not show up for my initial appointment or if I don't cancel my appointment at least 24 hours before my scheduled appointment time that I will be charged a $100.00 fee. I agree as an existing patient, if I do not show up for my scheduled appointment or if I do not cancel my appointment time, that I will be charged a $25.00 fee or up to $200 fee depending on the service that I am scheduled for.

Financial Agreement for Promotion Patients: I understand and agree that if I am a promotional patient (such as Groupon, Living Social, Amazon, Money Mailer, Connection Magazine and all others), whether I am a new or existing patient, If I do not show up for my scheduled appointment or if I do not cancel my appointment at least 24 hours before my scheduled appointment time, that I will be charged a $25.00 fee or up to $100 fee depending on the service that I am scheduled for.

Financial Agreement for Surgery & Procedure: I agree as a surgical and/or procedural patient to pay a deposit of 50% of my surgical/procedure fee at the time of booking and I agree to make the final payment at least 2 weeks prior to my scheduled surgery/procedure date. This also applies to packages. I understand and agree that if I purchase, I must pay 50% of the total amount upon scheduling my first appointment for that service and I understand and agree to pay the remaining balance on my first appointment before having the service. I agree and understand that all deposits are non-refundable.

Anesthesia: A board Certified Anesthesiologist will be participating in some surgical procedures and will be discussed by my provider. I agree that this fee is additional to my surgical fee and is due 2 weeks prior to my schedule surgery.

HIIPA: I acknowledge that I have received a copy of the HIIPA privacy regulations.

Clothing and Valuables: I fully understand that the spa is NOT responsible for any personal property (clothing, eye glasses, dentures, etc.) brought in or retained in the spa at any time. I fully understand that any valuables (money, jewelry, and keys) should be given to a family member or other responsible party for safe keeping.

Acknowledge of Driving Risks: I have been informed by the spa that I should not drive for at least 24 hours after completion of my surgical procedure. A responsible adult upon discharge from the spa will accompany all patients who have received sedation, including oral and intravenous sedation. All patients who have had local anesthesia without sedations and who meet the discharge criteria may be discharged unescorted.

Advance Directive/Living Will: Do you have an Advance Directive or Living Will? ___YES ___NO

If yes, do you want one today? ___YES ___NO

Patient Signature

I certify that I have read and reviewed this entire form and understand all of its contents and significance and I agree to follow the required procedures as indicated in this entire form.

Patient Signature: _____

Witness Signature: _____