

The Laser Skin Center

PLEASE BRING COMPLETE SIGNED FORM WITH YOU TO YOUR CONSULTATION.

OFFICE POLICIES

Name: _____

Please read and initial each paragraph signifying that you understand the following policies.

_____ I have been notified and fully informed that the procedure to be done is a cosmetic procedure as defined by the insurance industry. I understand that Cosmetic procedures/services are determined to be "not medically necessary". This procedure can not be filed with any insurance company for payment or reimbursement by myself or any other party. I hereby agree to be held personally and fully responsible for payment of the entire treatment packages at the quoted costs/expenses.

_____ I understand that cosmetic procedures are not an exact science. Although the staff strives for the best results with all treatments, the efficacy may vary among individuals. I may see excellent results, partial results, or no results. Refunds will not be requested or expected by me.

_____ In fairness to other clients who are waiting to receive scheduled appointments, I agree to provide a full 48 hours advanced notice if I am unable to keep my appointment. I understand that missed appointments or cancellations with less than 48 hours notice will incur a \$50 fee.

_____ I understand that children and guests are not permitted in any procedure room for any reason due to significant medical and safety risk. Children under 10 years old are not permitted unattended in the waiting room at any time. Staff members are not permitted to supervise children.

_____ I have read and understand the consent(s) form(s) pertaining to my procedure(s). I agree to hold harmless and release from any liability The Laser Skin Center or any of its officers, or employees for any condition or result, known or unknown that may arise as a result of any treatment that I receive.

_____ I understand photos will be taken before, during and after any procedure for documentation in my medical record.

_____ I am aware that Dr. Jeffery G. Parker is also a Family Medicine Physician, trainer and educator for the laser procedures and that he may want to use my photos for medical education in lectures, power point presentations and research. I agree to allow Dr. Jeffery G. Parker use of my photos in the following way: (Please check all that apply)

- Chart use only
- In-office use before/after photo book
- Unrestricted use

I have read and understand the above stated policies.

Patient _____ Witness _____

Date _____