Patient Name: _____Date of Birth: _____

APPOINTMENT POLICY & SPA CHECK- IN

A 24-hour notice is REQUIRED for any rescheduling or cancellation of your appointments. If you fail to provide us with a 24-hour notice, a $25.00 fee will be added to your account. By signing below you acknowledge and agree to these terms.

Please arrive 30 minutes prior to your appointment to receive numbing cream when necessary and/or to complete any skincare analysis forms, and to relax and enjoy a complimentary beverage. For your comfort, we ask that you shower before any body service.

BEFORE & AFTER PHOTO CONSENT

I am authorizing EFC Medspa and its providers and staff members to take before & after pictures of the procedure(s) that will be performed on me. I understand that these pictures will only be used to determine the optimum outcome of my service and/or treatment. They will not be displayed for any reason.

SPA ETIQUETTE

To provide our guests the best experience, we ask that you please silence your cellphones. To maintain a quiet and relaxing environment, children over the age of 14 are welcome in the Spa by appointment only.

FINANCIAL AGREEMENT

Payment is due in full at the time of service. Acceptable methods of payment are cash, CareCredit, debit and/or credit card.

I understand that my insurance policy is a contract between myself and my insurance company; EFC Medspa is not involved in billing to your insurance company. If I have questions or concerns regarding my coverage for office visits, procedures, lab work, medications, or particular conditions, I am responsible for obtaining this information. I agree to pay in full for all services if I choose to have the service provided.

HIPAA

EFC Medspa upholds the standard of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum information to only those in need of your health care information, treatment, payment or health care operations, in order to provide health care that is in your best interest.
- You may refuse to consent to the use or disclosure of your personal health information, but *this must be in writing*.
- Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health Information (PHI). This information is critical in making appropriate medical decisions.

If you have any questions regarding this consent, please speak with one of the staff of EFC Medspa.

TREATMENT CONSENT AND AUTHORIZATION

I consent to medical screening and medical examination to determine my current health status, other medical evaluations, diagnostic procedures, routine care, and medical treatments which the medical and professional staff of EFC Medspa may deem necessary, advisable, or appropriate. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

My signature here indicates compliance with the above policies and consent.

Signature: _____ Date: _____