



First / Last Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Main Phone#: _____ Secondary Phone#: _____

Email Address: _____

Occupation: _____

Who may we thank for referring you? _____

CONSENT TO PHOTOGRAPH:

I, the undersigned, do hereby authorize *McRae MD Medical Laser Spa* to photograph my treatment areas for my medical record and I agree that the negatives, prints, or digital images may be used for:

Patient Education(office only) Lecture/Demonstration Website(no identifiers)

Client Signature: _____ Date: _____

FINANCIAL POLICY & HIPPA CONSENT

We appreciate you choosing us for your Aesthetic Services. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the Aesthetic services received.

-I understand that I am responsible for all payments at the time of service, and that no insurance is accepted by *McRae MD Medical Laser Spa* but an itemized receipt can be provided at the time of service and may be submitted to your insurance for reimbursement if allowed by your insurance plan.

This form permits *McRae MD Medical Laser Spa* to use and/or disclose your identifiable health information to include the date and type of treatment you received. Your information will only be shared with the individuals that you list below. This authorization **HAS NO EXPIRATION DATE.** By signing this authorization, I authorize *McRae MD Medical Laser Spa* to use and/or disclose certain protected health information about me to:

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____