DFW Medical Spa
1009 Glade Road, Ste. E
Colleyville, TX
469-279-9897

Client Registration Form - Cancellation Policy - HIPPA Acknowledgement

Name: _____ Today's Date:_____

Address: _____City, State, Zip_____

Email Address: _____ Mobile Phone:_____

Date of Birth: _____ Sex: M _____ F _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

How did you hear about DFW Medical Spa?

_____

PAYMENT AND CANCELLATION POLICIES
Payment is expected from you in full at the time of service for all treatments. For your convenience, we accept cash, personal checks, Visa, MasterCard, American Express, and Discover. We request 24 hours notice for cancellation of any appointment. Failure to provide at least 24 hours cancellation notice may result in an advance deposit being required from you for future appointments. Your signature below indicates that you understand and accept these policies.

_____
Signature of Patient or Legal Guardian Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
You understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your protected health information. A copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of your health information is available upon request. You understand that Aesthetic Medical Center has the right to change its Notice of Privacy Practices from time to time and that you may contact this organization at any time to obtain a current copy of its Notice of Privacy Practices.

_____
Signature of Patient or Legal Guardian Date