

West Georgia Laser Center

Hair and Vein Removal Sun Spot Removal Skin Rejuvenation Titan

Office Policies

Name: _____

Please **read and initial each paragraph** signifying 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 cannot 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 procedure at the agreed upon cost.

_____ I understand that cosmetic procedures are not an exact science. Although our 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.

_____ I understand that all **packages are valid for one year from date of initial service**. After one year, any remaining treatments will be forfeited.

_____ In fairness to other clients who are waiting to receive scheduled appointments, I agree to provide a 48 hour advanced notice if I am unable to keep my appointment. **I understand that missed appointments or cancellations with less than 48 hour notice will result in a forfeit of that treatment. For the initial treatment, there is a \$50 cancellation fee.**

_____ I understand that children and guests are not allowed in any treatment 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 form(s) pertaining to my procedure(s) and I agree to hold harmless and release from any liability West Georgia Laser Center or any of it’s officers or employees for any condition or result known or unknown that may arise as a result of any treatment that I receive.

_____ By initialing, I acknowledge that I have read this form, that I fully understand it’s contents and that I have been given ample opportunity to ask questions and that all my questions have been answered to my satisfaction.

I have read and understand the above stated policies.

Patient

Witness

Date: _____