Hair & Vein Removal • Sun Spot Removal • Restylane • Botox • Skin Care

COSMETIC 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 entire procedure at the above cost/expenses.

_____ 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.

_____ 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 10yrs. 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 IM&P Wellness 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.

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

_____ I am aware that Dr. Wilson is speaker, trainer and educator for medical procedures and that she may want to use my photos for medical education of other physicians in lectures, power point presentations and research. I agree to allow Dr. Wilson to use my photos in the following way: (Please check all that apply) ☐ Chart use only ☐ In-office use before/after photo book ☐ Unrestricted use.

_____ Under Florida Law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida Law. By initialing, I acknowledge that I have read this form, that I fully understand its 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____________________