CONSENT TO PHOTOGRAPH

(check one or both)

☐ I consent to be photographed during the course of my treatment with Refresh Your Spirit Aesthetics. I understand that the purpose of such photographs is to track the progress of my treatment(s). I understand that my photographs are part of my medical records and therefore, are the property of Refresh Your Spirit Aesthetics.

☐ I consent to the use of my photographs, at the discretion of Refresh Your Spirit Aesthetics for marketing, research, educational and/or scientific purposes. I understand that every attempt will be made to protect my identity and my name will not be disclosed.

Print Patient name:____

Signature:____ Date:__________________

PRIVACY

I have read and fully understand all the terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent.

Print Patient Name:____

Signature:____ Date:___________________