POLICY PAYMENT

I understand that my treatments at Refresh Your Spirit Aesthetics require payment upon services rendered and the prices and fee structure for treatment have been explained to me. The quoted price for treatment is the price for each individual treatment session, unless otherwise specified in writing by the Refresh Your Spirit Aesthetics. For cosmetic medical procedures, I understand that the services often require more than one session to achieve the best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There are no refunds on treatments paid in advance, however any money paid can be used toward another treatment. Any refunds will be determined on a case-by-case basis after appropriate management approval and or sufficient reason. I further understand that the services offered by Refresh Your Spirit Aesthetics are elective in nature and are not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. We accept payment in the form of cash, or most major credit cards.
_____ (Please Initial)

CANCELLATION AND LATE POLICY

We understand that sometimes it is necessary to re-schedule or cancel an appointment; however, we ask that 24 hours' notice is given prior to cancelling.

In the event, that you are unable to give us 24 hours' notice, a cancellation fee of $50.00 will be billed to your account. We regret any inconvenience this may cause._____(Please Initial)

RETURN POLICY

All sales of skin care and makeup products are final. Unopened products may be returned with a receipt for a credit within 30days. _____ (Please Initial)

DISCLAIMER

I understand that all medical cosmetic treatments are provided exclusively by Refresh Your Spirit Aesthetics. I will not hold Refresh Your Spirit Aesthetics, its owners or its employees responsible for the results I experience. I realize that results may vary. I further understand that Refresh Your Spirit Aesthetics cannot prescribe an exact number of treatments to satisfy everyone's opinion and that the number of treatments I complete will be at my own discretion._____ (Please Initial)

I understand that even with the best equipment and the highest trained and board-certified medical providers, there are a percent of patients that are non-responders and will not have a desired response/outcome to treatments
_____ (Please Initial)

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:_____