

I can request a copy of Aislinn Medical Spas Notice of Privacy Practices for Protected Health Information at any time. I understand that Aislinn Medical Spa has the right to change this Notice of Privacy Practices at any time. I may obtain a current copy at Aislinn Medical Spa. The undersigned does hereby acknowledge receipt of Aislinn Medical Spa’s Notice for Protected Health Information.

*I give Aislinn Medical Spa permission to disclose personal health information about me to the following:*

Name of other individual: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

*I reserve the right to add or delete names to this list any time.*

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**No Show and Cancellation Policy**

In order to accommodate our clients to the best of our ability, we appreciate the courtesy of a call if you are unable to keep an appointment. Please notify our office at least 24 hours in advance if you need to cancel or reschedule. For appointments with our esthetician and/or massage therapist, we may require a credit card to be placed on file and reserve the right to charge this card under the circumstances below.

SPA Membership Members: In the event you do not call to cancel 24 hours in advance, a \$25 cancellation fee will be added to your next appointment. If you do not call to cancel 1 hour before your scheduled appointment or do not show for your scheduled appointment, you will be charged full price for the scheduled service.

NON Membership Members: In the event you do not call to cancel 24 hours in advance, a \$25 cancellation fee will be added to you next appointment. If you do not show up for your scheduled appointment, you will be charged a \$25 no-show fee.

*By signing below, I authorize Aislinn Medical Spa to charge my account for any the reason(s) stated above.*

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Photographic Consent (Choose one Option Below)**

\_\_\_\_\_ **I would like my pictures to remain private.** I understand that pictures of the areas to be treated will be taken. These are intended for comparison of the effectiveness of the stages of treatment. These images will remain private.

\_\_\_\_\_ **You may use my pictures as you need for education or advertising purposes (See below)**

In consideration of my being accepted as a person to be treated and for other good and valuable consideration herein acknowledged as received, upon the terms herein after stated, I hereby grant this facility, their legal representatives and assigns, those for whom Aislinn Medical Spa is acting, and those acting with their authority and permission, the absolute right and permission to copyright and use, re-use and publish, and republish photographic portraits or pictures of me or in which I may be included, in whole or in part, or composite or distorted in character form.

I also consent to the use of any printed matter in conjunction therewith as long as my identity is withheld. I do understand that in some circumstances the photographs may portray features which shall make my identity recognizable. I hereby waive any right that I may have to inspect or approve the finished product or products or the advertising copy or printed matter that may be used in connection therewith or for the use which it may be applied. I hereby release, discharge, and agree to save harmless this facility, their legal representatives or assigns, and all technicians and staff members involved in the taking of said picture(s) or of any subsequent processing thereof, as well as any publication thereof. I hereby warrant that I am of legal age and have every right to contract my own name in the above regard. I state further that I have read the above authorization, release and agreement, prior to its execution, and that I am fully familiar with contents thereof.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_