Acknowledgement and Consent

____ (*Initial*) **RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (print patient name)_____________________________, have read a copy of Vitalogy Skincare's Notice of Privacy Practices. (This document is available at the front desk or at Vitalogyskincare.com.)

____ (*Initial*) **CANCELLATION POLICY**

In fairness to other patients and your doctor, we require at least 24 hours notice to cancel appointments. Unless cancelled at least 24 hours in advance, you may be charged a fee for a missed appointment. This fee is not covered by insurance; it will be your responsibility to pay. Please help us serve you better by keeping your scheduled appointment.

____ (*Initial*) **RELEASE OF MEDICAL INFORMATION**

I do / do not (circle one) authorize Vitalogy Skincare and its designated representatives to release medical information to (print name)_____________________________ Relationship________________________

____ (*Initial*) **CONTACT PERMISSION**

In the event that Vitalogy Skincare needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Check all that apply:

☐ Leave a message on an answering machine

☐ Speak with spouse / significant other

☐ Speak with other family members

____ (*Initial*) **FINANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Vitalogy Skincare for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however I will be billed if any procedure is denied, considered cosmetic, or not paid in a timely manner. **If you do not have insurance coverage**, payment in full is due at the time of your visit unless payment arrangements are made prior to your appointment.

My signature below indicates that I have read and agree with all statements initialed above.

____ ______ _________________

Signature of Patient (or guardian) Date

3010 Williams Dr, Suite 177
Georgetown, TX 78626
512.868.3376
FAX 512.869.5868

1464 E. Whitestone Blvd, Suite 301
Cedar Park, TX 78613
512.260.3376
FAX 512.260.1177

901 Cypress Creek Rd, Bldg 1
Cedar Park, TX 78613
512.763.3800
FAX 512.996.8891

1320 Wonder World Dr, Suite 108
San Marcos, TX 78666
512.393.3376
FAX 512.754.3378

202 CR 340 A, Suite 4
Burnet, TX 78611
512.756.2525
FAX 512.756.2533

441 Hwy 71 West Suite E
Bastrop, TX 78602
512.763.3777
FAX 512.321.9400