## California Cosmetic Medical Institute

## PATIENT REGISTRATION

In order to provide you the most appropriate care, we would appreciate your time in completing the following questionnaire. All information is strictly confidential.

Name: _____Date of Birth_____

Address: _____

City/State/Zip: _____

Phone: _____ Cell:_____

Email: _____

Emergency Contact: _____Phone:_____

Referred by: _____

How do you prefer we contact you: Email Cell Phone Home Phone

Would you like us to E-mail our specials to you: **Y N** Confirmation of appointments: **Y N**

**Payment:**

**Payment is required at the time services are provided.**
Prepaid Series of treatments are NON-REFUNDABLE and NON-TRANSFERABLE.
Prepaid Series of treatments expire one year after first treatment.
Credit balances will be applied to future bills only.
Skincare items are not returnable 30 days after purchase.
We do not accept payment by check.

**Payment Options:**

Debit/ATM MasterCard Visa Discover American Express Care Credit Cash

**Cancellation Policy**:
A $50.00 Cancellation fee will be charged if appointments are not cancelled 24 hours in advance.

**Release of Information**:
Client/Guardian hereby authorizes the release of all information necessary to process payment. If you need your records please sign Medical Record Release Form. We have up to 15 days to release the records.

**Client/Guardian fully understands and agrees to these terms and conditions.**

_____ _____
**Signature of Client** **Signature of Guardian if Client is a Minor**

_____ _____
**Date** **Date**