CONWAY WOMEN'S CWMS MedSpa

PATIENT REGISTRATION FORM

Name: _____
First Middle Last

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

E-Mail Address: _____

Who referred you? _____

MedSpa Policies

For your benefit, we respectfully request a 24-hour cancellation notice for individual services and a 48-hour cancellation for multiple appointments. Less notice for missed appointments will result in a $50.00 service charge. For the safety of your children we cannot allow them in the laser treatment room and childcare is not available. In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. We accept cash, check, Mastercard, Amex or Visa. Your signature below indicated that you understand and accept this policy.

_____ _____
Signature of patient or legal guardian Date

Do we have permission to:

Leave a message on your answering machine at home? (circle)	Yes	No
Leave a message at your place of employment?	Yes	No
Discuss your medical condition with any member of your household?	Yes	No

If yes, whom: _____

_____ _____
Patient Signature Date