



Patient Information

Today's Date _____

Name _____ DOB ____/____/____ Age: _____
Last First

Address: _____

City State Zip

Cell #: (____) _____ Home Phone: (____) _____

Work Phone: (____) _____ Employer _____

E-Mail Address: _____

Emergency Contact : Name _____ Relationship _____
Phone # _____

How did you hear about us? _____ Did someone refer you here? _____

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Cosmetic Solutions sends text message reminder 1 day in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hour notice.

If you do not cancel or reschedule your appointment with at least 24 hour notice, we may assess a \$50 "no-show" service charge to your account for 2 "no-shows" in a row. This "no-show charge" is not reimbursable. You will be billed directly for it. After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand the "no-show" policy of Cosmetic Solutions and agree to provide a credit card number, which may be charged \$50 for any no-show of a scheduled appointment. I understand that I must cancel or reschedule any appointment at least 24 hours in advance in order to avoid a potential no-show charge to the credit card provided.

Notice of Privacy Practice

I received a Notice of Privacy Practice on _____ / _____ / _____
Patient Signature _____