**PERPETUAL BEAUTY AND WELLNESS**

**FINANCIAL/OFFICE POLICIES**

Please remember that your health insurance is a contract between you, the patient, and your insurance company. It is YOUR responsibility to know your health plan benefits, including co-payment amounts, deductibles, co-insurance, required referrals, and lab contracts.

Perpetual Beauty and Wellness will accept all major Canadian insurance plans.

**Self-Pay Patients:** Self-Pay or uninsured patients are responsible for payment at the time of service. The fee schedule is based on the establishedschedule in place. Self-pay patients must keep a credit card on file.

**Non-Covered Services:** Cosmetic and aesthetician services cannot be submitted to insurance, and payment in full is due at the time of service by credit card, check, or cash.

**Missed & Cancelled Medical Appointments:**

* Please provide at least one business day notice to cancel a medical appointment. We do this so your appointment slot can be offered to another patient in need of attention. You will be charged a $100 fee if you fail to keep your appointment or cancel/reschedule with less than 1 business days’ notice.
* Surgery & Cosmetic appointments: Cosmetic patients must maintain a credit card on file. We require at least 2 business days’ notice to cancel or reschedule an appointment. If you fail to keep your surgery or cosmetic appointment, your credit card will be charged a $100 fee.
* For larger procedures, 50% of the estimated fee will be collected as a deposit at the time of scheduling, and this deposit will be forfeited if the appointment is cancelled or rescheduled with less than 2 business days notification.
* After TWO missed appointments in a row or same day cancellations, you may be dismissed from the practice.
1. **Cosmetic Consultations:** The cosmetic consultation has a fee of $125 plus tax. The base cost of $125 will be reduced from the cost of any cosmetic procedure or treatment scheduled within 90 days of the consultation. A credit card on file is required and will be charged a cancellation fee of $100 if the consultation is rescheduled or cancelled without 2 business days notification.

**Cosmetic packages:** We offer packages on several cosmetic treatments as a way of cost savings to our patients. The full cost of the package is to be paid in full at the first session. Packages are non-transferable to any other person. If a patient opts to terminate the package prior to completion, the treatment(s) received will be charged the full cost per treatment (not the discounted package cost), and the patient will be refunded the remaining amount. Refunds can only be requested within 6 months of the first treatment. Packages must be completed within 12 months of purchase.

I have read and understand the Financial/Credit Card on File/Office Policies of Perpetual Beauty and Wellness.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient

**PATIENT PHOTOGENIC CONSENT FORM**

I hereby consent to the taking of photographs and/or film and sound recordings of me or parts of my body (hereinafter referred to as the “Materials”) and grant Perpetual Beauty and Wellness. and/or its Practitioners and/or their designee permissions to publish, redistribute, and otherwise use such Materials in any and all of its publications.

I understand and agree to transfer any and all rights I may have in and to these Materials, and that they will become the property of Perpetual Beauty and Wellness and/or the practice’s Practitioners and will not be returned.

I understand that the Materials may be published by Perpetual Beauty and Wellness. and/or its Practitioners or a third party in any print, visual or electronic media, specifically including, but not limited to, newspapers, magazines, medical journals and textbooks, pamphlets and the internet, for the purpose of informing the medical profession or the general public about aesthetic and skin care

I hereby irrevocably authorizePerpetual Beauty and Wellness and/or its Practitioners to edit, alter, copy, exhibit, publish or distribute these Materials for purposes of publicizing Perpetual Beauty and Wellness’s services or programs or for any other lawful purposes including, but not limited to:

* Medical purposes related to the case
* Scientific purposes, including seminars, medical articles or educational presentations.

Society for Aesthetic conference and Annual Meeting, website or other venue

* Before & After photo album (digital or printed) for cosmetic patients to view in office
* Before & After photographs and/or digital images to be included in newsletter to be sent to patients
* Before & After photographs and/or digital images to be included in our website and/or social media channels for aesthetic practice

Permission is specifically granted for the work to be edited, altered, used in whole or in part, in conjunction with other images, graphics, text and sound in any way whatsoever and without restrictions in any way that Perpetual Beauty and Wellness and/or its Practitioners, or their designee(s) may consider appropriate to achieve the purposes for which, or comply with the limitations subject to which, this consent is given. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness or altered likeness appears.

I understand that the Materials may portray features that may identify or otherwise present a recognizable likeness of me

Additionally, I waive any right to royalties or other compensation arising from or related to the use of any Materials and understand that the copyright to all Materials is retained by Perpetual Beauty and Wellness. and/or its Practitioners. The photographer shall own all Material rights, which shall accrue to the benefit of his/her successors, legal representatives and assigns. Perpetual Beauty and Wellness and/or its Practitioners need not approach me again for authorization to use these Materials.

I hold Perpetual Beauty and Wellness. and their designees harmless from any liability related to the use of these Materials for the purposes outlined above. I hereby hold harmless and release and forever discharge Perpetual Beauty and Wellness and/or its Practitioners and their designees from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate, have or may have by reason of me signing this Standard Patient Photogenic Consent Form.

I am at least 18 years of age and am competent to contract in my own name. I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Standard Patient Photographic Consent Form and fully understand its terms.

If the patient signing is under 18 years of age or under any incapacity, there must be consent by the patient’s conservator, guardian or health care representative as follows:

I hereby certify that I am the legal representative of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and do here by give my consent without reservation to the foregoing Patient Photogenic Consent Form on behalf of this person.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Guardian Date

**CONSENT TO TREAT MINOR CHILDREN**

(when seen under someone else’s supervision – non-parental)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby consent to any medical care determined by Perpetua Nwosu, MBBS, CCFP or other medical provider within Perpetual Beauty and Wellness to be necessary for the welfare of my child while said child is under the care of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and I am not reasonably available by telephone to give consent.

This authorization is effective from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Signature of Parent or Legal Guardian* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Witness Signature Witness Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* This additional information will assist in treatment if it can be furnished with the consent, but it is not required. Contact:

Mother’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to drugs or food \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications or Pertinent Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician where applicable \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE of PRIVACY PRACTICES**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

We have summarized our responsibilities and your rights at the beginning of the Notice of Privacy Practices. For a complete description of our privacy practices, please review this entire notice.

Our Responsibilities Summary Our practice is required to:

* Maintain the privacy of your health information
* Provide you with this notice of our legal duties and privacy practices with respect to information we collect and maintain about you
* Abide by the terms of this notice

Your Rights
As a patient at our practice, you have several rights in regard to your health information, including the following:

* The right to request that we not use or disclose your health information in certain ways.
* The right to access and obtain a copy of your health information.
* The right to request an amendment to your health information.
* The right to an accounting of disclosures of your health information.

We reserve the right to change our privacy practices and to make the new provisions effective for all health information we maintain. Should our privacy practices change, we will post the changes in our office. A copy of the revised notice will be available after the effective date of the changes upon request. We will not use or disclose your health information without your authorization, except as described in this notice.

If you have any questions about this Notice please contact our office at (236) 607 -5700

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Patient or Legal Guardian Date

**CONFIDENTIAL COMMUNICATION REQUEST**

Please read the following choices and tell us whether or not we can leave voice mail regarding your medical information, such as lab & test results, and with whom we may leave it. Please choose one of the following:

I DO CONSENT Perpetual Beauty and Wellness to leave detailed messages:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give Perpetual Beauty and Wellnessstaff permission to leave telephone messages regarding my medical care with the following options: (Initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

❒ Answering machine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials \_\_\_\_\_\_\_\_\_\_\_ ❒ My cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials \_\_\_\_\_\_\_\_\_\_\_ ❒ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials \_\_\_\_\_\_\_\_\_\_\_ ❒ Spouse (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials \_\_\_\_\_\_\_\_\_\_ ❒ Other (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Phone number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials \_\_\_\_\_\_\_\_\_\_ ❒ Other (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials \_\_\_\_\_\_\_\_\_\_

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_**

I DO NOT CONSENT to leave detailed messages on my phone or answering machine or with any member of my family.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_

If not signed by patient, please indicate your relationship to the patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_I do NOT wish to receive email promotions about events and special offers from Perpetual Beauty and Wellness.

 CARE DURING COVID-19

We are open for in office appointments, and our staff continues to wear medical-grade masks for all patient interactions. We are also continuing to offer Telehealth virtual appointments when appropriate based on patient needs.

## Patient expectations for in-office visits

If you are coming in for an appointment, we request that you follow these guidelines:

* Observe local guideline on COVID-19
* You must be free of symptoms, including, but not limited to cough, fever and body aches
* Please come to your appointment alone, if possible

If you have questions, please give us a call at (236) 607-5700 or send us an emailinfo@perpetualbeautyandwellness.com