Bullock
CENTER FOR AESTHETICS

CLIENT INFORMATION SHEET

Client Name:_____ Today's Date:_____

Date of Birth:_____ Sex: Male _____ Female _____

Home Address:_____ City:_____ State:___ Zip Code:____

Home Phone: (_____)_____Work Phone: (___)_____

Marital Status: Married __ Single __ Divorced __ Profession: _____

Emergency Contact Name and Phone:_____

Email Address: _____

How were you referred to us: _____

Primary Care Physician's Name: _____

What Pharmacy Do You Prefer: _____ Location: _____

I, _____, hereby agree for Bullock Center For Aesthetics to send my Insurance Information to Clinical Pathology Laboratory (CPL). I understand that some items or services provided to me may not be covered by my insurance and that I may receive a bill from CPL. I understand I am personally responsible for any non-covered items or services provided to me. This includes, but is not limited to; Bloodwork, Pap Smears, Cultures, Biopsies, etc. I understand that once services are billed to my insurance that Bullock Center For Aesthetics is not responsible for lab fees or any other charges I may receive from CPL or any other source.

Client Signature: _____ Date: _____

Witness: _____ Date: _____

CANCELLATION / NO SHOW POLICY FOR BULLOCK CENTER FOR AESTHETICS & GYNECOLOGY

Cancellation / No Show Policy $50.00 Fee:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **If an appointment is not cancelled at least 24 hours in advance you will be charged a fee of $50.00, this will not be covered by your insurance company.**

Scheduled Appointments

We understand that delays happen however we must try to keep the doctor and aestheticians on time for other patients. **If a patient is 15 minutes past their scheduled appointment time, we will have to reschedule the appointment.**

Print Name_____**Date**_____

Patient Signature_____

Witness_____**Date**_____