



PATIENT ACKNOWLEDGEMENT AND AGREEMENT PRIVACY PRACTICES:

Patient Name: _____

Date of Birth: _____

I acknowledge that BELEZA MEDSPA provided me with a written copy of his/her Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature

Date

Personal Representative Signature (if applicable)

Relationship to Patient

I acknowledge that I have read and fully understand this consent form.

I understand the risks associated with the communication of e-mail as set forth in this consent form.

Despite the risks associated with e-mail, I agree that my BELEZA MEDSPA and his/her workforce may use e-mail to facilitate communications to or about me. I understand that disclosures regarding my treatment and diagnosis may be made to not only me, but also internally within BELEZA MEDSPA or to appropriate third parties for services such as billing.

Patient Signature: _____

Date: _____

Witness: _____

Date: _____