

# REYNOSO MD

Skin and Laser Center

## Client Rights/Responsibilities and Cancellation Policy

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We are committed to serving you with compassion, care and respect. As one of our valued patients and/or clients, you are entitled to the following:

### YOU HAVE THE RIGHT:

- To be treated with respect and dignity
- To know the names and professional status of the person(s) serving you
- To privacy and confidentiality
- To receive accurate information about your health-related concerns
- To know the effectiveness and potential side-effects of all forms of treatment
- To participate in choosing the form of treatment best suited to your skin
- To receive education and counseling about treatments
- To review your medical record with your clinician
- To amend your records
- To receive any information about potential services or related services

### YOU HAVE THE RESPONSIBILITY:

- To seek medical attention promptly and to provide useful feedback
- To be honest about your medical history
- To be honest about your sun exposure
- To ask questions about anything you do not understand
- To follow health advice and instructions
- To report any significant changes in your health
- To respect clinic policies
- To show up to appointments or cancel 48 hours in advance

I authorize REYNOSO MD Medical Center, LLC/REYNOSO MD Skin and Laser Center to perform the treatment or procedures recommended. I acknowledge no guarantee; either expressed or implied has been made to me regarding the outcome of any treatment or process.

I fully understand that it is impossible for anyone to make a guarantee regarding the outcome of my medical treatments and/or procedures.

I understand I am financially responsible for all procedures due when services are rendered. We require a credit card to be kept on file. In the event that you miss a scheduled appointment, do not cancel your scheduled appointment 48 hours prior or if you are a "No Show" which is considered arriving more than 10 minutes late for an appointment, your card will be charged for the full service price.

I authorize the release of information to a licensed physician of the facility's choosing for the purpose of professional interpretation and establishment of their recommendations.

Client Name(Print)\_\_\_\_\_

Client Signature\_\_\_\_\_

Date\_\_\_\_\_

Witness\_\_\_\_\_

Date\_\_\_\_\_