CONROE FAMILY DOCTOR
caring for your family as we would our own

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LASER FINANCIAL CONSENT

Patient Name _____ DOB _____

CONSENT TO TREATMENT (Please initial next to each line)

_____I understand and agree that I am consenting to receive cosmetic services. This is strictly a voluntary cosmetic procedure. No treatment or service is necessary or required. The risks and complications associated with treatments or services have been explained to me by the physician and/or staff. I freely and voluntarily agree to undergo the treatment or service. I understand that Conroe Family Doctor Laser Clinic services generally consist of a series of treatments and services to achieve maximum benefit and this consent shall apply to all services rendered to me.

NO GUARANTEE

_____I UNDERSTAND THAT NO GUARANTEE HAS BEEN GIVEN AS TO THE RESULTS THAT MAY BE OBTAINED BY ANY OF THE SERVICES OR TREATMENTS OFFERED BY Conroe Family Doctor Laser Clinic. Best efforts will be made to deliver excellent result and it is understood that patient compliance with recommendations is critical for optimal outcomes.

FINANCIAL RESPONSIBILITY FOR TREATMENT

_____I understand that cosmetic services are not medically necessary, and therefore not covered by insurance or other third party payers. I understand that I am fully responsible to pay for all services rendered to me.

_____ _____

Patient/Guarantor Signature **Date**