ALC MEDSPA

EST. 2004

PATIENT CONSENT TO TREATMENT

Patient Name:_____ **Date of Birth:**_____

Thank you for choosing ALC Medspa. In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessary to help you fully understand it. Please sign only after careful review and consideration. **YOU MAY REQUEST A COPY OF THIS FORM FOR YOUR OWN RECORDS.**

I, the undersigned, do hereby request and consent to an evaluation and treatment by ALC Medspa and its staff. I will inform ALC Medspa or its staff who is treating me of any sensitive areas or adverse conditions that I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

I understand that the following medical and/or diagnostic treatment ("**Treatment**") is planned for me and I voluntarily consent and authorize this Treatment:_____

_____

I have been informed of the possible risks and complications associated with the Treatment. I understand these risks and I have been given the opportunity to have all of my questions answered to my satisfaction. I accept these risks and elect to undergo the Treatment.

I have read and understand the post-treatment care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my Treatment or suggested home post-treatment care, I will consult ALC Medspa immediately.

I have disclosed a full and accurate personal medical history, including any and all information regarding medical conditions and my use of medications, drugs, herbs, vitamins, or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of complications.

I certify that I am a competent adult of at least 18 years of age.

I clearly understand and agree that all services rendered to me, the below-named patient, may be charged directly to me and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me up to the point of termination will be immediately due and payable.

My signature attests to the fact that I have fully read this entire consent form, that I have had any concerns answered to my satisfaction, and that I understand and agree to the information contained within.

_____ _____

Signature of Patient/Personal Representative **Date**

_____

Relationship to Patient

_____ _____

ALC Medspa Representative Name **Signature of ALC Medspa Representative**

5101 Washington St. Suite 13
Gurnee, IL 60031
(847) 263-4343