530-842-3261 • RDBMD@claritymedicalspa.net
106 Ranch Lane • Suite B • Yreka, CA 96097

Patient Registration

Patient Name:_____ Date of Birth: _____

Address:_____ City:_____ State:_____

Zip code:_____

Home Phone: _____ Work:_____ Cell: _____

Email: _____

May we contact you by email: YES / NO (please circle one)

Would you like to receive the monthly email specials: YES / NO (please circle one)

Parent/Guardian (if under 18): _____ Phone: _____

I understand that full payment is due at the time services are rendered unless purchasing a package, in which case full payment is due in advance of services. I understand that payment may be made by cash, check, Visa, or MasterCard. Any returned checks are subject to a $25 fee._____ (Patient Initial)

I understand that I am allowed only a one time no-show appointment and subsequently a fee of $15 will be charged to my account with Clarity Medical Spa if I do not show up for future appointments and I have not called to cancel with at least 24 hour's notice. _____ (Patient Initial)

By initialing below, I do hereby agree to the following: I am allowing Clarity Medical Spa to take photos of my treatment and/or treated areas to be used for the purpose of monitoring my progress. _____ (Patient Initial)

We do offer some special pricing on treatment packages. However, once the package is purchased we do not offer refunds._____ (Patient Initial)

Patient Signature:_____

Printed Name:_____