SACRAMENTO HAIR DOCTOR

NALINI G. PRASAD, M.D.

PATIENT REGISTRATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State:_____ Zip:_____

❑Home #: _____ ❑Cell #: _____ ❑Work #:_____

**Please indicate your preference for a contact number by checking the appropriate box.

Email Address: _____

**May we contact you by email? ❑Yes ❑ No **May we contact you by text? ❑Yes ❑ No

Driver's License Number: _____ Exp. Date: _____

Emergency Contact Name: _____ Phone #: _____

Whom may we thank for referring you? _____

PATIENT EMPLOYER INFORMATION

Employer's Name: _____ Occupation: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree that the cosmetic services provided by Nalini Prasad, MD, and/or such assistants at Laser Esthetica and/or Sacramento Hair Doctor are elective in nature and are not covered by medical insurances. Therefore, payments are due in full at the time the services are rendered. Because of the elective nature of these treatments, I understand that there is a no refund policy for any services or treatments rendered.

Because each appointment time is reserved for me and therefore cannot be used for another client, there will be a $50 charge for missed appointments unless I cancel two business days in advance.

I further understand that there is a $25 charge for any returned checks. By signing this statement, I agree to the terms above.

_____ _____

Patient Signature Date