For office use only
Reviewed :
Date:

Name: _____Date of Birth:_____

Address:_____

Email address (appt reminders, updates, promotions) :_____

Best Contact # :_____ Emergency Contact Name: _____ Phone # _____

Preferred Pharmacy : _____

How did you hear about us? (Please circle/specify)

Google Search	Social Media	Brochure/Flyer	Billboard	Graystone Eye	Magazine
Friend/Other:					

Medical History

Please circle any of the following conditions that you have or have had in the past:

Diabetes	Keloid Scars	Glaucoma
Hypertension (high BP)	Seizures	Dry Eyes
Bleeding Disorder/ Use of Blood Thinner	Hernias	Thyroid problems
Hepatitis or HIV	Metal Implants	Skin sensitivities
Skin Cancer	Respiratory Illness (lung issues)	Neurological disorder
Psoriasis or Vitiligo	Abdominal Mesh	Autoimmune disorder
Heart attack	Stroke	Difficulty with anesthesia
Other (please specify):		

Do you smoke? ☐ No ☐ Yes

List any current medications:

List any medication allergies:

_____

List any previous cosmetic procedures that you have had:

_____

Please circle all areas of concern and/or interest:

Wrinkles	Sun damage/ dark spots	Tattoo Removal	Skin rejuvenation	Waxing
Drooping eyelids	Redness/Rosacea	Facials	Hair removal	Cosmetic surgery
Acne	Eyelash enhancement	Massage	Fat removal	Permanent cosmetics
Other:				

I certify that I have provided accurate medical history to Graystone Aesthetic Center.

_____ _____ _____

Signature of patient/guardian Print Name/Relationship Date

Agreement & Signature

Thank you for choosing Graystone Aesthetic Center for your aesthetic needs. This document details what we ask of you as we enter a partnership to provide you with the best care and experience during your time with us.

Appointments- Graystone Aesthetic Center will strive to contact and remind you of your scheduled appointments. To ensure that your appointment begins promptly and you are able to receive the full time for your service, please arrive promptly for your appointment to allow for the check-in process and to complete any required paperwork. If you are more than 15 minutes late to your appointment, the provider may not be able to proceed with your treatment if there is another patient scheduled to follow. We request a courtesy call if you know you will be late. ☐

Cancellation Policy/Rescheduling Fee- For all appointments scheduled, we kindly ask for a minimum of 24 hours notice of cancellation. A Rescheduling Fee of $35 will be charged for cancellations less than 24 hours or No Call/No Shows. If you have an appointment and NO SHOW twice, we will require a non-refundable 50% prepayment for the next appointment service scheduled. If appointment is kept, the 50% *will* go towards the treatment. Prepayment will *not* be refunded for appointment cancellations less than 24 hours notice. ☐

Appointments Requiring Deposits- For appointments that require a considerable amount of time to be blocked, a non-refundable $50 deposit will be required. This will apply to Dermal Filler, Permanent Cosmetic/ Microblading treatments, and Cosmetic Consultations**. If the appointment is kept, the deposit will be applied to your first completed treatment. If you are unable to keep your scheduled appointment, a *minimum* of 48 hours notice is required to apply the deposit to a future appointment. An additional $50 deposit will be required to reschedule for cancellations less than 48 hours prior to your appointment. ☐

**Cosmetic Consultations are scheduled with Dr. Hargrove to discuss surgical cosmetic concerns. The fee for cosmetic consultations is $100. A $50 deposit will be collected upon scheduling and the remaining $50 will be collected upon completion of your consultation.

Payment Policy- Due to the cosmetic nature of our practice, all payments are due at time of service. ☐

Product Return Policy- The North Carolina Board of Pharmacy (NCBOP) states that in order to insure purity and safety of all prescriptive products, returns of said products will be declined once the product has left this office. This includes allergic reactions, irritation or any other reason. It is important that you understand this policy and are aware at the time of purchases. A copy of this document will be kept in your chart and available for you to review at any time. This policy applies to all products purchased in the Aesthetic Center. ☐

Photography Policy- For many procedures, before and after photos are taken for documentation which are kept in your records in the Aesthetic Center. On some occasions, we may choose to use your photos with identity protection, for educational or marketing purposes. Photos will *only* to be used in the office for print, visual or electronic media for general education of the public. Should Graystone wish to use your photos outside of the office for online publishing or social media, you will be required to sign a separate consent. By signing below, you release Graystone Aesthetic Center, Dr. Hargrove and it's agents from any and all claims and demands arising out of, or in conjunction with the use of the photos.
If you wish to **decline** the use of your photos in the office please circle : **OPT OUT**

Use of Email/Text – I agree to the use of my email address and phone number for correspondence relating to Graystone Aesthetic Center, including marketing material, updates, and appointment reminders. Graystone Aesthetic Center will never provide these details to third parties and I have the right to unsubscribe at any time. Please circle: **YES / NO**

I certify that I have read the above statements and understand the terms. If under 18, parent or guardian must sign.

_____	_____	_____
Patient Name or Parent/Guardian	**Signature**	**Date**
_____	_____	_____
Witness Name	**Witness Signature**	**Date**