MOSAIC
Med Spa • Laser Center

Dr. Sarah J. Blank, M.D.
Dr. Laurence R. O'Halloran, M.D.
Dr. Timothy J. Egan, M.D.

Today's Date:			
PATIENT INFORMATION			
Patient's Last Name:	First Name:		Middle Initial:
Patient's Age:	Date of Birth: / /	Sex: ☐ Male ☐ Female	
Address:	City:	State:	Zip Code:
Primary Phone:	Secondary Phone:		
E-Mail Address:			
Whom may we thank for referring you to our practice?			

Payment Collection
I understand that payment is due at the time of service. I understand that I am personally responsible for any and all costs. I understand that a service will not be booked until a deposit has been paid.

Cancellation Policy and Fees
I understand that 48-hour notice is required to cancel all appointments and that if sufficient notice is not given, then my deposit will not be returned to me. If I cancel or re-schedule the appointment at least 2 working days prior, my deposit will be refunded to me, or credited towards my next appointment.

Signature: ______________________________ **Date:** ____________