SIX ZONES

botox & fillers

REBECCA A. PAPPALARDO, MD

CLIENT RIGHTS AND RESPONSIBILITIES

We are committed to serving each patient with compassion, care, skill, and respect. As one of my patients, you have choices, rights, and responsibilities:

- To be treated with dignity and respect
- To know the names and professional status of those serving you
- To privacy
- To confidentiality of your records
- To receive accurate information about your health-related concerns
- To know the effectiveness, possible side-effects and problems of all forms of treatments
- To participate in choosing a form of treatment
- To receive education and counseling
- To refuse or consent to care/treatment
- To change your care provider
- To review your medical record with your clinician
- To receive information about services and costs
- To seek medical attention promptly
- To be honest about your medical history
- To ask anything you do not understand
- To follow health advice and instructions
- To report and significant changes in health or medications
- To respect professional policies of office locations
- To keep appointments or cancel in advance
- To seek non-emergency care during regular business hours and to provide useful feedback regarding our services and policies

I authorize Dr. Pappalardo to perform the treatments recommended. I acknowledge that no guarantees either expressed or implied have been made to me regarding the outcome of treatment/procedure. I fully understand that it is impossible to make guarantees regarding outcome of treatment/procedure.

I understand that I am financially responsible for all amounts due for services rendered. I also understand that a follow up visit (2) weeks after any injection will be recommended and requested by Dr. Pappalardo for optimal results.

I authorize the release of information to a licensed physician for the purpose of professional interpretation and establishment of treatment plan.

I have received a copy of my Rights/Responsibilities form.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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