ROYALTREATMENT
HAIR RESTORATION CENTER

Client Consent to Receive Services for Medical Wig

Client Name: _____ DOB: _____

CONSENT TO RECEIVE SERVICES Initial _____

I hereby authorize Royal Treatment Hair Restoration Center to render appropriate services to the client/client named above for the purpose of obtaining a medical wig. I understand that in order to receive the appropriate type of medical wig that a consultation, either in person or virtually, must occur. I recognize and agree that I have the right to refuse treatment or terminate services at any time by notifying Royal Treatment Hair Restoration Center in writing. In addition, Royal Treatment Hair Restoration Center may terminate services by notifying me of termination and the reason.

MEDICARE/ MEDICAID/PRIVATE INSURANCE/OTHER BENEFITS PAYMENT AUTHORIZATION Initial _____

If applying for reimbursement of the cost of the wig thru commercial health insurance or FSA/HSA, I certify that the information given by me in applying for benefits is correct. I authorize release of all records required to act on my application. I request and approve that payment of authorized benefits be made to Royal Treatment Hair Restoration Center on my behalf for the purchase of the medical wig.

PAYMENT FOR CONSULTATION Initial _____

I understand that I will be charged by Royal Treatment Hair Restoration Center __$150_____ per hour for an initial consultation to discuss preferences in customizing the medical wig and obtaining measurements. I understand that no work will be done on the medical wig until a consultation is conducted, either in person or online. Late cancellations on the day of service consultation will still be charged the minimum bill rate of 1 hour. There are no exceptions to the late cancellation policy.

CLIENT'S SIGNATURE

This form must be signed by the Royal Treatment Hair Restoration Center client unless the client is a minor, incompetent, or physically incapable of signing.

I have read and fully understand the content of this Consent to Receive Services Form and hereby agree to and authorize the foregoing provisions.

As used in this document, the terms "I', "me" and "my" refer to and include, in addition to the undersigned, the client/client named above and others for whom the undersigned is responsible or for whom the undersigned has assumed responsibility in engaging Royal Treatment Hair Restoration Center to provide services to the client/client.

Client Signature: _____ Date: _____

Revised: 10/13/2022

Authorized Signer: _____ Date: _____
(Minor, incompetent or physically incapable of signing)

Royal Treatment Hair Restoration Center Signature: _____ Date: _____