Photo/ HIPAA Financial Consent form

Authorization for Use and Disclosure of Protected Health InformationPictures, Video, and /or Testimonials – written or electronic.

Pure Envy Med Spa

Please input Date of Birth

What is being disclosed?

I understand this authorization covers all photographic or video images of the Patient and/or any written or electronically submitted testimonials pertaining to the Practice (herein collectively referred to as the “Information”); and grants the right to the Practice to reproduce, use, and disclose the Information for medical purposes, with or without the Patient’s name or other personally identifiable information. This authorization to use is given to the Practice listed above and, by extension, its employees, contractors, and/or Business Associates (according to their Business Associate Agreement).

Who is receiving it?

I understand this authorizes disclosures of the Information to contractors and/or Business Associates of the Practice and subsequently any persons, without limitation, who may view the information in printed or digital form in promotional materials including social media or internet sites

Why is it being disclosed? The purpose of this authorization is to permit the Information to be used for marketing of the Practice, and I explicitly consent to the use of the Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided in exchange for the use of the Information.How long is this authorization good for?This authorization remains valid during two years from the day it was signed, unless effectively revoked in writing by the Patient before that date or event.

Right to revoke:

I understand that I, as the Patient (or parent/legal guardian of the Patient) may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice and will not apply to the extent that the Practice has previously acted in reliance on the authorization. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control, but cannot guarantee full removal. I understand that protected health information already used or disclosed prior to any revocation may no longer be protected.

Condition of Treatment:

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this authorization, and that my decision not to sign will not influence or affect the Patient’s treatment in any waySubject to re-disclosure:I understand that protected health information once used or disclosed is no longer protected under federal medical privacy law and is subject to re-disclosure. I acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re- disclosure of the Information.

Condition of Treatment:

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this authorization, and that my decision not to sign will not influence or affect the Patient’s treatment in any way.

Subject to re-disclosure:

I understand that protected health information once used or disclosed is no longer protected under federal medical privacy law and is subject to re-disclosure. I acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re- disclosure of the Information.

I understand I will be provided with a copy (either paper or electronic) of this authorization upon request.

Social Media Consent

Additionally, I have the option to consent to the Practice using the Information for promotional purposes on social media platforms. Please indicate your preference below:

Multi Choice

- [ ] Yes
- [ ] No. I acknowledge that without consenting to photos and videos being takem during the course of my treatments, I am waiving my rights to any refunds on my services rendered. I accept and understand it is my choice to refuse photos and videos. I accept all the above.

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Signature

Tap here to sign

09/08/2025Please input First namePlease input Last name

HIPAA

This Notice of Privacy Practices describes how we may use and disclose your protected health/personal information (PHI) to carry out out treatment, payment or business operations (TPO) and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected information. Protected health/personal information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health/Personal Information.

Your protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to support business operations of this office, if requested by you to a finance company to pay for your care, and any other use required by law.

Treatment: We will use and disclose your protected health/personal information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health/personal information, as necessary, if, as a result of our services, you require treatment by a physician. Your protected health/personal information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health/personal information will be used, if requested, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health/personal information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law, communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors, and organ donation; research; criminal activity and national security; workers compensation; inmates; required uses and disclosures. Under the law, we must make a disclosure to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health/personal information.

You have the right to inspect and copy your protected health/personal information. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected health/personal information.

You have the right to require a restriction of your protected health/personal information. This means you may ask us not to use or disclose any part of your protected health/personal information for the purposes of treatment or healthcare operations. You may also request that any part of your protected health/personal information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If our medical director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your protected health/personal information will not be restricted. You then have the right to use another service provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to amend your protected health/personal information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health/personal information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2009.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health/personal information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, , HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE

Signature

Tap here to sign

Financial Agreement for Services

This Financial Agreement ("Agreement") is entered into between Pure Envy Med Spa, hereinafter referred to as the "Provider", and the undersigned client, hereinafter referred to as the "Patient".

1. Appointment Deposit:

- I understand that a deposit is required to secure my appointment at Pure Envy Med Spa. This deposit is non-refundable but may be applied toward my treatment or rescheduled appointment if I provide at least 24 hours' notice of cancellation or rescheduling. Failure to provide sufficient notice or failure to attend my appointment will result in the forfeiture of my deposit. By signing this consent form, I acknowledge and accept this policy and authorize Pure Envy Med Spa to process the deposit and any applicable fees according to this agreement

2. Payment Terms:

- The Patient agrees to pay for services in full at the time they are rendered.
- Accepted forms of payment include [All major Credit Cards, Cash, Care Credit, Affirm & Cherry)

3. Payment Terms for Packages:

- The Patient agrees to pay for the entire package upfront or according to the agreed-upon payment plan.
- If the patient does not complete the entire package, no refunds or partial refunds will be provided for the unused portion, however, upon providers discretion, a credit may be applied to utlize in the Med Spa.
- No refunds will be issued for any services completed.
- No refunds on prepaid services not rendered, yet a credit will remain on account for future purchases.
- No refunds on retail products, no exceptions.

4. Credit Card Authorization:

- The patient authorizes the provider to charge the credit card on file for the total amount due for services rendered.
- In the event of any dispute or chargeback initiated by the patient, the Patient agrees to reimburse the Provider for any associated fees, including chargeback fees and legal expenses.

5. Informed Consent:

- The patient acknowledges that they have been fully informed about the services provided, including potential risks and benefits.
- The patient has had the opportunity to ask questions and has received satisfactory answers regarding the services.

6. Expiry and Usage Period:

- The package purchased by the patient has an expiry date or a defined usage period.
- It is the responsibility of the patient to complete the services within the specified timeframe.

7. Dispute Resolution:

- In the event of a dispute, the patient agrees to contact the provider first to attempt to resolve the issue amicably.
- Any disputes that cannot be resolved amicably will be subject to arbitration in accordance with the rules of the American Arbitration Association (AAA).

8. Governing Law:

- This Agreement shall be governed by the laws of Florida/USA.

9. Agreement Modifications:

- Any modifications to this Agreement must be made in writing and agreed upon by both parties.

09/08/2025

Tap here to sign