info@completeimage.org
(440) 461-4247
6555 Wilson Mills Rd, Ste. 105
Mayfield Village, OH 44143

Complete Image

Notice of Cancellation Policy

Complete Image requires a 24-hour notice of appointment cancellation to avoid penalty.

Complete Image reserves the right of refusal after multiple appointment cancellations or “no call, no shows.”

If you arrive more than 10-15 minutes late to your scheduled appointment, the provider may not be able to perform a service that day.

If you fail to arrive for your scheduled appointment without a 24-hour notice, a percentage of the missed service will be due upon your next appointment.

Of course, we understand when emergencies arise but please be mindful of your providers’ and fellow clients’ time.

We also ask that in the case that if you fall ill on the date of your appointment, that you reschedule your appointment for at least 48 hours after you starting exhibiting symptoms. This would not be cause for any penalty.

Return Policy

At Complete Image, we strive to provide products and services that best met the client’s standards.

If you feel that we are not meeting these standards, please let us know within **one week** of the purchase.

Beyond that point, we are not able to provide a replacement of these services or products

Complete Image
Acknowledgements

Patient Name: _____

I hereby acknowledge that I have received a copy of the Complete Image Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

I hereby acknowledge that I have received a copy of the Complete Image Cancellation Policy.

I hereby acknowledge that I have received a copy of the Complete Image Return Policy.

_____ **Signature of Patient or Legal Representative**

_____ **Date**

_____ **Printed Name of Patient's Representative (*if applicable*)**

Relationship to Patient (*if applicable*)
- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

Patient Intake Form

Basic Information

Full Name: _____
First Middle Last Suffix

Sex: ◯ Male ◯ Female ◯ Unknown **Date of Birth:** _____/_____/_____

Primary Phone: ◯ Home ◯ Mobile ◯ Work **Phone Number:** _____

Email: _____

Address Line 1: _____ **Address Line 2:** _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact

Full Name: _____
First Middle Last Suffix

Primary Phone: ◯ Home ◯ Mobile ◯ Work **Phone Number:** _____