CLIENT APPLICATION

Name (First, Middle Initial, Last): _____

Address: _____

City/State/Zip: _____

Phone Number (H): _____ (C): _____

Email: _____

Diagnosis: _____

How did you hear about us? _____

Have you ever worn a cranial prosthesis or wig before? Yes ☐ No ☐

If so, how long ago? ☐ 0-6 months ☐ 6-36 months ☐ 3+ years

Explain:

Physician's Name: _____

Office Name: _____

Location: _____

Phone: _____

Fax: _____

TERMS:

Ahead of Beauty reserves the right to provide no more than (1) unit per recipient within a 3-year period. Ahead of Beauty is not responsible for services performed that did not receive prior approval and/or fall outside the scope of the approved unit. Maintenance services are the full responsibility of the Recipient. Contract stylist may provide any additional services as needed or requested at the sole financial responsibility of Recipient.

I have read, understand, and agree to the terms of this application:

- A Picture of your current government issued Photo ID is required ahead of your consultation
- Front & Back photo of your medical insurance provider card (if applicable)
- Pictures of hair styles you are interested in are required ahead of your consultation
- Previous photos of yourself with a preferred hairstyle are helpful ahead of your consultation

Recipient Signature: _____

Date: _____

Ahead of Beauty's Mission is to support the healing powers of appearance while respecting each person's dignity and privacy during all services. To provide 100% no cost cranial prosthesis to qualifying individuals suffering hair loss due to cancer drugs and/or treatments, alopecia, burns and other medical conditions.

submittals@aheadofbeauty.org