PATIENT APPLICATION

Recipient Name (First, Middle Initial, Last): ____

Address: ____

City/State/Zip: ____

Phone Number (H): ________________ (W): ___________________ (C): __________________

Email: ____

How did you hear about us? ____

Have you ever worn a cranial prosthesis before?

Yes ☐ No ☐

If so, how long ago?

☐ 0-6 months ☐ 6-36 months ☐ 3+ years

Explain:

____

____

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TERMS:

Ahead of Beauty reserves the right to provide no more than (1) wig per recipient within a 5-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 wig. 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. Customization of any wig services can only be provided to in person recipients/applicants. All out of state recipients will be provided a quality human hair cranial prosthesis (wig) of choice without customization.

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
- This application and verification must be emailed from the physician/provider office directly to Submittals@aheadofbeauty.org

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.