Beauty Salon

Application for Beauty/Barber Salon Charging Privileges.

Dear Family Members,

This Form Must Be Filled Out Completely, Before Any Services Are Done.

Please fill out and return to the salon, with your payment, or by fax or email below. The Responsible Party is the person responsible for payment, other than the resident. A statement of charges is emailed monthly and bills are due upon presentation. If payment is not received within 15 days of our statement generated, a no payment fee of $10.00 will be applied.

Resident's Name: _____ has permission to receive the following services at _____ (Facility Name). **REQUIRED**

	WEEKLY	2 WKS	4-6 WKS	6-8 WKS	3-4 months
Shampoo-Set	_____	_____	_____	_____	_____
Haircut	_____	_____	_____	_____	_____
Shampoo and Cut	_____	_____	_____	_____	_____
Hair Color	_____	_____	_____	_____	_____
Perm Wave	_____	_____	_____	_____	_____
Shampoo Only	_____	_____	_____	_____	_____
Dandruff Shampoo	_____	_____	_____	_____	_____
Color Rinse	_____	_____	_____	_____	_____
Conditioner	_____	_____	_____	_____	_____
Manicure	_____	_____	_____	_____	_____
Pedicure	_____	_____	_____	_____	_____

_____ **Gratuity** (Optional)

CHECK IF NO SERVICES DESIRED_____ IS THE RESIDENT DIABETIC? Yes or no

Responsible Party Information (We do not accept credit/debit cards)

- **ALL FIELDS NEED TO BE FILLED OUT COMPLETELY. OUR STATEMENTS ARE EMAILED ONLY. WE DO NOT MAIL STATEMENTS. WE DO NEED YOUR PHYSICAL ADDRESS FOR CREDIT PURPOSES, STATEMENTS WILL BE EMAILED.**

- **Residents can not charge to his/her room. Charging is for responsible party only. If resident is responsible, payment is due at time of service.**

TODAY'S DATE: _____

_____
Responsible Party Name (Please Print)

_____
Responsible Party Signature
(Void if signed by resident*)
(See * below)

_____
Mailing Address-# and Street
(**Bank only for P.O. Box**)

(_____)_____
Phone Number

_____
City, State ZIP

_____
Email Address to receive monthly statement (REQUIRED)
PLEASE ADD hbpcorp@hbpcorp.com to your email's contact list to avoid spam delivery

_____ **Please initial if funds are to be withdrawn from facility trust account.**

HBP Corporation OFFICE (602) 867-1464 Fax (602) 493-0953 www.hbpcorp.com