# Client Information and Medical/Physical History

In order to provide you with the most appropriate treatment, please complete the following medical history form.

Client Name _____ Today's Date_____

Date of Birth_____ Age_____ Occupation_____

Home Address_____ City_____ State_____ Zip_____

Home Phone_____ Work_____ Cell _____

Preferred contact mode: Cell / Home / Work *Provide carrier if you would like text reminders* _____

Email _____ *For reminders, special events or other important information only*

Emergency Contact Name & Phone_____

How did you hear about us?

- ❑ Another client. Whom may we thank? _____
- ❑ Our website.
- ❑ Printed media. Which publication? _____
- ❑ A staff member. Name: _____
- ❑ Other _____

**Procedures or issues of interest to you: (please check all that apply)**

- ❑ Botox product
- ❑ Dermal fillers
- ❑ Facial fat transfer
- ❑ Liposuction/body contouring
- ❑ Skin tightening (ThermiTight, Ultherapy, Forma)
- ❑ Laser skin resurfacing ($CO^2$)
- ❑ Coolsculpting
- ❑ Cellulite
- ❑ Laser hair removal
- ❑ Other_____
- ❑ Facials
- ❑ Chemical peel
- ❑ Hydrafacial MD
- ❑ Microdermabrasion
- ❑ Micro-needling/Dermapen
- ❑ Photo-Facial (IPL)
- ❑ Acne or acne scarring
- ❑ Waxing
- ❑ Skin care products

**Skin Type:**

- ❑ Always burns, never tans
- ❑ Sometimes burns, always tans
- ❑ Always burns, sometimes tans
- ❑ Rarely burns, always tans

Do you smoke? NO YES How much? _____

Alcohol Use:

- ❑ NONE
- ❑ Moderate (2-3 times weekly)
- ❑ Regular (daily)
  How much?_____

## MEDICAL HISTORY:

Are you currently under the care of a physician (other than annual exam?) NO YES
If YES for what:

_____

Are you currently under the care of a dermatologist (other than annual exam?) NO YES
If YES for what:

_____

Do you have (or have had) any of the following medical conditions? (Please check all that apply)

- ❑ Cancer
- ❑ Heart disease
- ❑ Herpes
- ❑ HIV
- ❑ Hepatitis
- ❑ Arthritis
- ❑ Skin cancer
- ❑ Frequent cold sores
- ❑ Rosacea
- ❑ Bleeding disorder
- ❑ High blood pressure
- ❑ Diabetes

Do you have any other health problems or medical conditions – not listed – that may help us in your treatment plan?

---

## MEDICATIONS & ALLERGIES

Do you have any allergies to ANY medications? NO YES Please list ALL & TYPE of reaction you experience:

_____

Do you have allergies or sensitivities to the following?

- ❑ Latex
- ❑ Lidocaine/Novocain
- ❑ Any antibiotics
- ❑ Aspirin
- ❑ Hydroquinone for skin lightening
- ❑ Hydrocortisone
- ❑ Adhesive tape
- ❑ Codeine
- ❑ Certain foods (list)

Please list ALL medications (including over-the-counter) you are currently taking: NONE

_____

What vitamins/herbal supplements do you regularly use? _____

**Client signature**_____ **Date**_____

## Scheduling, Deposit & Cancellation Policy *(please read and sign)*

Due to the popularity of our treatments and procedures, it is necessary to make an advance appointment reservation for any of our services. However, we will always do our best to accommodate your last minute requirements. Our policies are in place so that we minimize waiting times and provide the highest standards of service for all our clients.

**Cancellations and Missed Appointment:** Should you need to cancel or reschedule, please contact us 48 hours in advance of your scheduled appointment time. All cancellations with less than 48 hours notice are subject to a $50.00 cancellation fee. Missed appointments/no shows will be charged a $50 fee.

**Saturday Appointment:** We require a valid credit card at the time of booking to secure your appointment. Your card will not be billed unless you miss your appointment/no show or cancel within 48 hours of your scheduled appointment.

**Surgery Deposit:** Once you have selected your surgery date, we require a $300 deposit to hold your day and time. If you must cancel your surgery, you must do so 7 days prior to your procedure day otherwise the deposit will be forfeited. Full payment is due no later than 7 days prior to your procedure. If you aren't scheduled for a pre-surgery appointment, payment can be made over the phone with a major credit card.

**Consultation Deposit:** All consultations must be secured with a $50.00 deposit upon scheduling the appointment. This deposit is non-refundable and will be applied towards any treatment or procedure. This fee is forfeited if you do not show for your appointment or cancel within a 48 hour period.

**Gratuity:** Gratuity is not accepted for physician services. However, it is customary to give a gratuity to your facial aesthetician or massage therapist if you are satisfied with the service received. For aesthetician services costing over $150, the gratuity should be based on $150.

### *A few important notes regarding any cosmetic procedure….*

When deciding to undergo a cosmetic medical procedure or treatment you need to keep a few things in mind.

1. The procedure is elective and not medically necessary.
2. Do not have a treatment immediately prior to an important event even if you have had the procedure before with no problem, as you may swell or bruise.
3. Weigh the risks and benefits for all your options.
4. Every procedure comes with a certain amount of risk – from mild to more severe complications. Although most complications eventually resolve with further treatment and/or time, they could include:
    - Redness, bruising and swelling
    - Allergic reactions from mild rash to an anaphylactic reaction
    - Burns from mild reaction like sunburn to a full thickness burn
    - Scarring, particularly with people with a history of keloid and hypertrophic scarring
    - Either darkening or lightening of existing pigment
    - Lumps, modules and unevenness
    - Unsatisfactory outcome

As a general rule, the more invasive the procedure, the higher risk of complication. Following the pre and post instructions carefully is key in avoiding complications and ensuring the best outcome. However, with cosmetic procedures, everyone responds differently. There are no guarantees. We encourage you to ask all your questions before you have any procedure realizing there is always another option, including not having the procedure.

**Client signature**_____ **Date**_____

**Parent signature**_____ **Date**_____

*(Parent or guardian signature required if client is under 18 years of age)*

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A complete version is available for your review at the front desk.

*What this is all about:* Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, text, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, _____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**Signature_____ Date:_____**