Patient Information Form

- Personal or Family History of **Seizures**? Yes No
- Have you ever had treatment of any veins? Yes No
- Accutane use in the past 6 months? Yes No
- Do you use tobacco products? Yes No
- Do you spend a lot of time outdoors? Yes No
- Currently pregnant or breastfeeding? Yes No
- Daily sunscreen use? Yes No
- History of **Cold Sores**? Yes No
- Do you use tanning booths? Yes No
- Have you ever had permanent make-up (tattoo)? Yes No
- Have you or are you currently having ANY cosmetic procedures? Yes No
- Are you currently having electrolysis, waxing, or laser hair removal? Yes No
- Have you ever had implants/fillers in the area to be treated? Yes No
- Do you have or have you ever experienced an ongoing skin infection (such as MRSA) that required antibiotics to treat? Yes No

- PLEASE ELABORATE ON ANY QUESTIONS MARKED “YES”:
- Do you have any **allergies**, if so, what are you allergic to?:
- PLEASE LIST PREVIOUS SURGERIES:

SKIN CONDITION

ARE YOU SENSITIVE TO:

AHA HYDROQUINONE PRESERVATIVES FRAGRANCES SULFA DRUGS ASPIRIN LATEX WOOL

WOULD YOU DESCRIBE YOUR SKIN AS: SENSITIVE RESILIENT NOT SURE

I AM INTERESTED IN (CIRCLE ALL THAT APPLY):

NEUROTOXINS Botox /Jeaveau /Dysport FILLERS (Belotero, Restylane, Juvederm) LASER HAIR REMOVAL LASER RESURFACING LASER VEIN REMOVAL MICRODERMABRASIONS THE SECRET RF TRUSCULPT ID MICRONEEDLING IPL B12 INJECTIONS KYBELLA WEIGHTLOSS LATISSE MEDICAL GRADE CHEMICAL PEELS SKIN CARE PRODUCTS LASER TEXTURING

OTHER:

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE.

CLIENT SIGNATURE: _____ DATE: _____

Consent to Communicate

Patient NAME:
Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message – if so, list cell carrier:			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

HIPAA Information and Consent Form

Patient Name:

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 more complete text is posted in the office.

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, U.S mail, 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 if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____