MD BODY & MED SPA

HEALTH HISTORY

Name: _____ Date: _____

Cell #: _____ Home #: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: F M

Occupation: _____

Emergency Contact Name: _____ Phone: _____

Relationship: Spouse Parent Friend Other_____

Please list all Medical Allergies _____

Please list all Skin Allergies _____

Yes No Are you sensitive to any of the following?

Detergents/Soaps Fabrics Lotions/Creams Perfumes

Medical History: Please indicate if you have experienced or are experiencing any of the following conditions:

Yes No Do you have any chronic medical conditions?

If yes, please list: _____

Yes No Are you currently in treatment for any medical conditions?

If yes, please list: _____

Yes No Are you currently under the care of a physician or dermatologist?

If yes, please state reason: _____

Yes No Do you use a sunscreen / sunblock?

Yes No Do you participate in outdoor activities?

If yes, when was your most recent sun exposure? _____

Yes No Do you have a history of skin cancer?

If yes, please state reason: _____

Yes No Have you had permanent cosmetics?

If yes, please indicate location(s): _____

Yes No Are you currently taking Accutane or have you been on it within the past year?

Yes No Have you ever had herpes?

If yes, please state treatment medications: _____

Yes No Are you currently taking medication(s)?

If yes, please list all medications: _____

_____

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☎ 303.466.0100

Yes No Are you currently taking any vitamins (Vitamin E, St. John's Wort)?

If yes, please list all vitamins: _____

Yes No Are you pregnant, or planning to become pregnant?

Yes No Are you currently on hormone replacement therapy?

Yes No Have you had any of the following: (if yes, specify)

Botox Injections Chemical Peels Cosmetic Surgery

Dermal Fillers Gold Therapy Laser Resurfacing

Other (please specify) _____

Yes No Are you currently using any of the following: (if yes, specify)

Differin Hydroquinone Retin A

Renova Tazarotene Tretinoin

Yes No Are you currently using skin care products?

If yes, please list brand and type: _____

Which skin conditions do you want to improve?

Acne/Acne Scarring Age Spots Enlarged Pores Fine Lines & Wrinkles

Hyperpigmentation (Brown Spots) Sun Damage Surgical Facial Scars

Other _____

What else would you like to improve about your skin? _____

_____

Is there any particular treatment you like to discuss today? _____

_____

Acknowledgement: *I certify that the preceding medical and personal history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical and health condition. A current medical history is essential for the caregiver to execute the appropriate treatment procedures.*

_____ _____

Patient Signature Date

_____ _____

Technician Signature Date

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MD
BODY & MED SPA

INFORMED CONSENT FOR

DERMAPLANING, FACIALS, MICRODERMABRASION, NON-SURGICAL FACELIFTS

Thank you for choosing MD Body and Med Spa. In our ongoing efforts to provide you with the best possible services we ask that you carefully review this procedural consent form and ask any questions necessary to help you fully understand it. This procedural consent form is used to provide proper consent for services exclusively rendered by MD Body and Med Spa. Please sign only after careful review and consideration.

Safety: All recommended and required safety precautions and guidelines will be followed to ensure the utmost in safety during your treatment.

Limitations: I understand that dermaplaning, facials, microdermabrasion, and non-surgical face lifts are elective cosmetic procedures and that no guarantees or medical claims are made or implied regarding its effectiveness or actual results. A series of treatments may be necessary to achieve maximum benefits.

Cautions: If I have any history of keloid formation, excessive scaring or poor healing (diabetes or other conditions) I will consult my personal physician prior to proceeding. Sun tanning or self-tanning creams must be avoided prior to and after treatments as these may reduce the effectiveness of the treatments and may increase side effects. Accutane (or similar medications) should not be used for at least six months prior and Retin-A (or products containing tretinoin) for at least two weeks prior to any treatment. Treatments cannot be performed on skin areas with open sores or lesions, including eczema. Tattoos and Permanent makeup in the treatment area may be altered. Recurrent viral infections such as herpes simplex (cold sores) or varicella (shingles) may be activated. An accurate medical history is to be completed and reviewed with any concerns addressed prior to treatment.

Pre and Post Treatment Instructions: I acknowledge receipt of pre-treatment instructions. I understand that failure to carefully follow these instructions may affect my treatment outcome and likelihood or severity of complications.

Pigment Changes: Hypo-pigmentation (decreased skin coloration) or hyper-pigmentation (increased skin coloration) is uncommon and rarely permanent, may last several weeks to months. Pre and post treatment use of sunblock is advised to minimize risk. With clients of Fitzpatrick III-VI may require bleaching creams prior to treatment.

I understand there may be some degree of discomfort; i.e., stinging, pin-pricking sensation, hotness, or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, I may need several treatments.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the Aesthetician who performed the treatment.

I agree to refrain from tanning in tanning booths while I am undergoing treatment, and during the 14 days following the end of treatment.

I understand that direct sun exposure is prohibited while I am undergoing treatment and that the use of sunblock protection with a minimum of SPF30 is mandatory.

I have not had any other treatments of any kind, within 14 days of the treatment. I understand I cannot have another treatment within 14 days of this treatment today, whether it is performed at this or any other location.

Long Term Risk: I understand that the risks of dermaplaning, microdermabrasions and non-surgical facelifts use may not be fully known. The information presented to me is based on recent studies conducted over a relatively short period of time. MD Body and Med Spa shall not be held responsible for any risk not yet or commonly known.

Continued Consent: This consent shall apply to all subsequent treatments of a similar nature.

Guarantee: No warranty or guarantee is offered or implied.

Acknowledgement: *I understand that the treatment I receive is provided for the purpose of relaxation, healthier skin, the release of toxins and treatment for certain skin conditions. If I experience pain or discomfort during my session, I will immediately inform the Aesthetician so that the products or technique may be adjusted to reach a level of desired comfort. Because certain therapies should not be performed under certain medical conditions, I affirm that I have stated my known medical conditions, and answered all questions correctly. I agree to keep the provider updated as to any changes in my medical profile and understand that there shall be no liability to MD Body and Med Spa should I fail to do so.* My signature attests to the fact that I have fully read this entire consent form, that I have had any concerns answered to my satisfaction, and that I understand and agree to the information contained within.

_____
Patient Name

_____ _____
Patient Signature Date

_____ _____
Witness Date

Consent of Treatment of Minor (if applicable):

By my signature below, I hereby authorize the Aesthetician at MD Body & Med Spa to administer facial treatment techniques to my child or dependent as they deem necessary.

_____ _____
Parent Signature Date

MD BODY & MED SPA

Cancellation/Rescheduling & Payment Policy

Payment: Payment in full is required on or before day of initial treatment. The following payment options are available:

Cash or Check: You may pay for your treatment with Cash, Check or Cashier's Check. All returned checks will be assessed a return check charge of $30.00 each time a check is returned, regardless of the reason.

Credit Cards: We accept Visa, MasterCard, American Express and Discover.

GreenSky: Medical finance program approved for our practice.

Punctuality: Please arrive 15 minutes early so you can be well-prepped and enjoy an unhurried transition into your treatment.

Arriving Late: Arriving late will interfere with your treatment, therefore, making the treatment time needed insufficient. Your treatment will end at your scheduled time not to interfere with the next appointment.

No show: We strongly encourage you to communicate with us. If you fail to arrive for your scheduled treatment time without having notified us, you will be subject to lose your deposit or future appointments. A no show will also disengage or void any agreements you may have with our office.

Cancellation: We take pride in the appropriate reservation of your procedural date and scheduled time. Our priority is to schedule procedures that can be attended to with the utmost of care. Our office scheduling policy is very time sensitive due to constraints of the procedure. Therefore, please understand the importance of respecting our one week cancellation/reschedule policy.

Our one week cancellation/reschedule policy is very strict. If you fail to reschedule your appointment one week prior to initial appointment, cancel or do not show, you are subject to lose your future appointments and or deposit / unused money.

Cancellaton 8 or more days prior to your scheduled appointment date: will result in 5% loss of all fess to cover Credit Card charges.

Cancellation 4-7 days prior to your scheduled appointment date: will result in a 25% loss of all fees.

Cancellation on the day of, or less than 72 hours prior to your scheduled appointment date will result in a 50% loss of all fees.

No refunds after initial treatment.

_____
Patient Name

_____ _____
Patient Signature Date

_____ _____
Witness Date

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Privacy Notice and Authorization

As you are no doubt aware, major changes in Federal privacy requirements – the HIPAA privacy regulations obligate most physician practices to provide notice about privacy rights and detailed policies designed to protect your privacy. These requirements were put into place because increased patient information is being shared in digital format over computer networks.

MD Body & Med Spa is committed to protecting patient confidentiality. You should understand the following with regard how we treat your personal health information.

1) When you register as a new patient, you will be asked to sign an authorization, also provided below, that includes a release of information that allows us to request and obtain records from practitioners that you have seen for the purpose of assisting us in your treatment. If you desire records to be sent to a health provider you have not yet seen, a family member, an attorney, or other party outside of this list, you must first sign a release of information before we can forward your information. You may be subject to fees.

2) We cannot release information to family members, other than parents or legal guardians, even if they are involved in your care, without your written permission.

3) In order to assure quality of care, MD Body & Med Spa records are occasionally reviewed both internally and by outside consultants in legal, clinical, and other concerns that affect the quality of services we provide. Only necessary information is accessed, and any such review is by a professional staff working under the condition of confidentiality.

4) If you wish to limit the nature of information that is released, or the parties noted above to whom information may be provided, please ask to meet with a MD Body & Med Spa privacy coordinator to discuss limitations. In some instances, MD Body & Med Spa may not be in a legal position to honor requested limitations.

5) We may be required by law, in some cases, to make disclosure of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies of the US Department of Health and Human Services.

6) Because MD Body & Med Spa is subject to HIPAA, MD Body & Med Spa practices long established and useful business practices, such as providing you with appointment reminders, notifying you of lab results, or using sign-up sheets, but we will take steps to do so in a fashion that takes your privacy expectations into account. Please inform staff of any limitations you would like us to honor in this regard.

7) MD Body & Med Spa reserves the right to charge for copying and forwarding your health records.

8) While the records of the care we provide are MD Body & Med Spa property, we will make them available for your inspection and provide copies at a reasonable fee. If you have any concerns about your health records, please ask to speak with a MD Body & Med Spa Medical Staff member.

9) I have been offered the patient right to review the Complete HIPAA compliance document and understand that MD Body & Med Spa will comply to protect my privacy.

Please acknowledge review of this notice and authorization of this release of medical information by signing below.

_____ _____

Patient Signature Date

_____ _____

Witness Date

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