



MED SPAS

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, please complete the following questionnaire. Information Provided is Confidential.

PERSONAL HISTORY

Client First & Last Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

How were you referred to us? _____

PROCEDURES THAT INTEREST YOU

Please put a check mark next to the services that interest you.

____ Botox

____ Laser Hair Removal

____ Fillers

____ Scar/Stretch Marks

____ Photofacial

____ Acne Treatments

____ Chemical Peel/Facial

____ Tattoo Removal

____ Fractional

____ Laser Liposuction (Non-Surgical)

____ Skin Resurfacing

____ Liposuction (Surgical)

____ Skin Tightening

____ Hormone Program

____ Cellulite Reduction

____ Other (please specify) _____

MEDICAL HISTORY

Are you currently under the care of a physician and/or dermatologist? ____Yes ____No

If yes, for what: _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ____Yes ____No

If Yes, please explain: _____

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

____Cancer ____Diabetes ____High blood pressure ____Herpes ____Arthritis

____Frequent cold sores ____HIV/AIDS ____Keloid scarring ____Skin disease/Skin lesions

____Seizure disorder ____Hepatitis ____Hormone imbalance ____Thyroid imbalance

____Blood clotting abnormalities ____Multiple Sclerosis ____Any active infection

____Other medical conditions/problems? Please list: _____

Do you have any dental work such as veneers, or dental implants? _____

Do you have any piercings, dermal implants, tattoos? Please list: _____

Have you ever had an allergic reaction to any of the following?
(Please check all that apply and describe the reaction you experienced)

Food_____ Latex_____ Aspirin_____ Lidocaine_____ Hydrocortisone_____

Hydroquinone or skin bleaching agents_____ Others_____

MEDICATIONS

Have you ever used (circle): Accutane or Retin-A® ?

If yes, when did you last use it? _____

What oral medications are you presently taking? (Please list)

What topical medications or creams are you currently using? (Please list)

SKIN HISTORY

Which of the following best describes your skin type? (Please check only one)

- Always burns, never tans Always burns, sometimes tans
 Sometimes burns, always tans Rarely burns, always tans
 Brown, moderately pigmented skin Black skin

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks?

Shaving Waxing Electrolysis Plucking Tweezing Threading Depilatories

Any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No

If yes, please describe: _____

Have you recently had any Botox or filler? Yes No

FOR OUR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? Yes No

Are you breastfeeding? Yes No

Are you using contraception? Yes No

SIGNATURE

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the Technician, Esthetician, Therapist, Doctor or Nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to give the best care and execute appropriate treatment procedures.

Signature: _____

Date: _____

CONDENSED HIPAA NOTICE OF PRIVACY PRACTICES

Your health is a serious personal matter and we understand that confidentiality is of utmost importance. To ensure your complete privacy, we implemented and follow specific strict security protocols and processes.

The Department of Health and Human Services has established a "Privacy Rule" to help insure that the privacy of your personal health care information is protected. Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We may also disclose protected health information to other physicians who are treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give your consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Representatives.

You have the right to review our complete HIPAA Notice of Privacy Practices that is posted at our front desk. You have the right to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

If you feel that your privacy rights have been violated you may contact us and ask for the Director of Operations. The director will investigate all claims and will provide you with a written report of their findings within 10 days. If you are not satisfied with the report and corrective action taken, the Director will provide you with an appropriate state or federal organization address and/or telephone numbers to file a complaint.

Patient name (Please Print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

INFORMED CONSENT FORM FOR LASER/IPL THERAPY

I understand that a LASER/IPL is being used for a treatment on me under the direction of NALA MED SPAS. Although LASER/IPL therapy is safe and effective in the majority of cases, unexpected adverse events may occur. Unexpected side effects may result from the use of the laser, and the expected response of the treated area may not be achieved.

____ 1. **Short term effects:** I understand there are multiple short term effects that may occur with LASER/IPL therapy, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, blistering, scabbing, crusting, flaking, and sensitivity to the sun. Although these effects typically resolve within several days, they may persist for several weeks and rarely, even longer. I understand that the degree of the side effects varies from person to person, and it may not be possible to predict how I will respond.

____ 2. **Possible permanent effects:** I understand that although most side effects are short term and resolve fairly quickly, some effects may be permanent. Scarring and changes in pigmentation (lighter skin or darker skin) may be permanent.

____ 3. **Discomfort associated with procedure:** I understand that the LASER/IPL functions by heating up its target (blood vessels, pigmentation). This heating sensation may be minimized by the use of the cooling device, but some level of discomfort may be felt. The level of discomfort depends on the treatment being done, and varies from person to person. The stinging or sensation of heat is typically short term but may persist for several hours after the procedure.

____ 4. **Effects of UV:** I understand that sun exposure, tanning beds, sunless tanning lotions, and tanning creams can cause discoloration or reaction to LASER/IPL treatment during and after the procedure. Having any kind of tan prior to therapy or soon after therapy results in an increased chance of blistering, permanent or temporary discoloration, scarring, and discomfort. I understand that avoidance of any UV exposure 1 month prior and 2 weeks after treatment reduces the risk of these effects.

____ 5. **People excluded from therapy:** I understand that certain patients should not have LASER/IPL treatment. This includes any patients who have sun exposure in treatment area, open wounds, malignant skin tumors, patients who have certain disease that make them sensitive to light, patients currently on Accutane, Isotretinoin, Sotret, Claravis, Amnesteem or who have been on Accutane, Isotretinoin, Sotret, Claravis, Amnesteem within in the last 3 months, and in many cases, patients who have tattoos in the area to be treated.

____ 6. **Need for multiple treatments:** I understand that many conditions being treated by the LASER/IPL will require multiple treatments to obtain the desired results. For laser hair reduction, the procedure works by targeting growing hair follicles, not dormant hair. Complete destruction of all hair follicles with a single treatment is therefore not possible, and multiple treatments are necessary. For redness/rosacea, results are seen after the first treatment, but multiple treatments are often necessary to remove the desired amount of redness/blood vessels, and multiple treatments are often necessary to smooth a blotchy appearance that may be present after 1 treatment. Everyone responds in different ways and different rates to the treatment.

____ 7. **Tattoo/permanent makeup:** If there are any tattoos or permanent makeup in the area, there is a possibility of blistering and lightening of the tattoo/makeup.

____ 8. **Photographs:** I understand that the physician/technician may choose to take photos of my treatment area for the purpose of monitoring my progress.

____ 9. **For permanent hair reduction:** I understand that there are other options for permanent hair reduction such as electrolysis, waxing, and chemical preparations. I understand the difference between these options and permanent hair reduction, and I am choosing LASER/IPL as a noninvasive treatment for my hair epilation. I also understand that the hair follicles that are treated are permanently destroyed, and may not grow back (this is especially important when treating certain areas such as the neck, beard/moustache area, scalp). Use of the laser is FDA cleared for permanent hair reduction, and it is possible that new hairs will grow at some point in the treated areas. Response to treatment varies from patient to patient.

____ 10. **For laser vein treatment:** I understand that this procedure involves a laser to coagulate the vessels and a bruising effect could last up to 6 months. It is possible the results will be minimal or not help at all. I realize that each individual's treatment response is different; therefore it could require multiple treatments to achieve desired results. Other options are available, and may include sclerotherapy and surgery.

____ 11. **For non-ablative LaserFacial:** I understand that erythema (redness) is a common immediate reaction from the LaserFacial treatment process. This typically resolves in 2 hours, but may last longer. I understand that 4-6 treatments are required for the non-ablative LaserFacial to be most effective, and it is important to follow the recommended maintenance schedule for future treatments to keep the best possible results. I also realize that each individual's treatment response may be different, and the number of treatments may vary to achieve desired results.

____ 12. **For laser treatment of redness/rosacea:** I understand that this procedure for reduction or elimination of redness/telangectasia/rosacea could result in a bruising effect that could last 2-3 weeks. It is possible that the results will be minimal or not help at all. Each individual's treatment response is different; therefore it could require multiple treatments to achieve the desired results.

____ 13. I understand that my insurance company will not cover the cost of laser therapy, and I am responsible for the complete cost of the service. Payment is due at the time of the treatment. I also understand that once I have started my treatment program, there are no refunds.

____ 14. I have received, read and understand the post-treatment instructions.

I have been explained the nature and purpose of the LASER/IPL treatment, including any risks and possible complications, and has discussed the contents of this form with me. I have read and understand this consent form, and I agree to its terms and authorize treatment. I further understand that there are no guaranteed results. I will not hold NALA MED SPAS or the employees responsible for my individual results.

Patient name (Please Print): _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____