beauty & body
Med Lounge & Spa

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date_____

Date of Birth _____ Contact Phone _____

If you would like to receive our monthly specials, please fill in your email address below:

_____

MEDICAL HISTORY

Do you regularly use tanning salons or sun bathe? _____ How often? _____

Are you currently under the care of a physician? ☐Yes ☐No If yes, for what:

_____

Are you currently under the care of a dermatologist? ☐Yes ☐No If yes, for what:

_____

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

☐Cancer ☐Diabetes ☐High blood pressure ☐Herpes ☐Arthritis ☐Vitiligo
☐Frequent cold sores ☐HIV/AIDS ☐Hepatitis ☐Keloid scarring ☐Skin disease
☐Skin Hyperpigmentation /Hypopigmentation ☐Seizure Disorder ☐Hormone imbalance
☐Thyroid imbalance ☐Pacemaker/defibrillator ☐Blood clotting abnormalities
☐Any active infection

Do you have any other health problems or medical conditions? 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 ☐Hydroquinone ☐Hydrocortisone

_____

MEDICATIONS

Do you have any medications allergy? ☐Yes ☐No Known Allergies If yes, please list:

_____

What current medications (including vitamins/supplements) are you taking? Please List:

_____

Are you on any mood altering or anti –depression medications? ☐Yes ☐No

_____

For female patients:

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

Are you breastfeeding? ☐Yes ☐ No

CLIENT INFORMATION & MEDICAL HISTORY

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 execute appropriate treatment procedures.

Signature _____ Date _____

Print Name _____

Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to, microablation, microdermabrasion, waxing, electrolysis, facial toning, permanent cosmetics, body treatments, ionization, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, Collagen, Dermal Fillers, PRP Injections, Sclerotherapy, Mesotherapy, Dermaplaning, and various other beauty procedures is not an exact science and no specific guaranties can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference.

I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insureds, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may effect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

Client Signature_____Date:_____

Printed Name_____

HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health/personal information (PHI) to carryout out treatment, payment or business operations (TPO) and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected information. Protected health/personal information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health/Personal Information**

   Uses and Disclosures of Protected Health/Personal Information
   Your protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to support business operations of this office, if requested by you to a finance company to pay for your care, and any other use required by law.

   Treatment: We will use and disclose your protected health/personal 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. For example, we would disclose your protected health/personal information, as necessary, if, as a result of our services, you require treatment by a physician. Your protected health/personal 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.

   Payment: Your protected health/personal information will be used, if requested, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval.

   Healthcare Operations: We may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment.

   We may use or disclose your protected health/personal information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law, communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors and organ donation; research; criminal activity and national security; workersï¿½ compensation; inmates; required uses and disclosures. Under the law, we must make disclosure to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

   Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

   You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

2. **Your Rights**

   Following is a statement of your rights with respect to your protected health/personal information.

   You have the right to inspect and copy your protected health/personal information. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected health/personal information.

   You have the right to require a restriction of your protected health/personal information. This means you may ask us not to use or disclose any part of your protected health/personal information for the purposes of treatment or healthcare operations. You may also request that any part of your protected health/personal information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

   We are not required to agree to a restriction that you may request. If our medical director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your protected health/personal information will not be restricted. You then have the right to use another service provider.

   You have the right to request to receive confidential communications from us by alternative

means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to amend your protected health/personal information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health/personal information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2009.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health/personal information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, ***Client Name*** HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE

Date

Print name

Date