Patient Intake Form

Client Information and 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.

Client Name _____ **Today's Date** _____

Date of Birth _____ **Age** _____ **Occupation** _____

Home Address _____ **City** _____ **State** _____

Zip Code _____ **Cell Phone** _____ **Home Phone** _____

E-mail address: _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

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

Are you currently under the care of a physician? ☐ 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 ☐ Frequent cold sores
☐ HIV/AIDS ☐ Keloid scarring ☐ Seizure disorder ☐ Skin disease/Skin lesions ☐ Hepatitis
☐ Hormone imbalance ☐ Thyroid imbalance ☐ Blood clotting abnormalities ☐ Any active infection

Additional health problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction? (List all that you have had and describe the reaction you experienced)

_____

What oral or topical medications are you presently taking? (It is required that you list all of them):

_____

Photographic Consent:

I give consent to be photographed for the purpose of medical records ☐ Yes ☐ No
I give consent to be anonymously photographed for marketing and/or publication ☐ 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

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional 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.

Patient Signature _____ Date: _____

Fitzpatrick Skin Type

The most commonly used scheme to classify a person's skin type by their response to sun exposure in terms of the degree of burning and tanning was developed by Thomas B. Fitzpatrick*, MD, PhD. Examples are given below.

* Fitzpatrick, T.B. (1988) The validity and practicality of sun reactive skin types I through VI. Arch Dermatol 124; 869-871.

Eye colour

0. Light colours
1. Blue, gray or green
2. Dark
3. Brown
4. Black

Natural hair colour

0. Sandy red
1. Blond
2. Chestnut or dark blond
3. Brown
4. Black

Your skin colour (unexposed areas)

0. Reddish
1. Pale
2. Beige or olive
3. Brown
4. Dark brown

Freckles (unexposed areas)

0. Many
1. Several
2. Few
3. Rare
4. None

If you stay in the sun too long?

0. Painful blisters, peeling
1. Mild blisters, peeling
2. Burn, mild peeling
3. Rare
4. No burning

Do you turn brown?

0. Never
1. Seldom
2. Sometimes
3. Often
4. Always

How brown do you get?

0. Never
1. Light tan
2. Medium tan
3. Dark tan
4. Deep dark

Is your face sensitive to the sun?

0. Very sensitive
1. Sensitive
2. Sometimes
3. Resistant
4. Never have a problem

How often do you tan?

0. Never
1. Seldom
2. Sometimes
3. Often
4. Always

When was your last tan?

0. +3 months ago
1. 2–3 months ago
2. 1–2 months ago
3. Weeks ago
4. Days

Score		
0–6	Skin Type I	Always burns, never tans (pale white skin) 
7–13	Skin Type II	Always burns easily, tans minimally (white skin) 
14–20	Skin Type III	Burns moderately, tans uniformly (light brown skin) 
21–27	Skin Type IV	Burns minimally, always tans well (moderate brown skin) 
28–34	Skin Type V	Rarely burns, tans profusely (dark brown skin) 
35+	Skin Type VI	Never burns (deeply pigmented dark brown to black skin) 

Laser Photorejuvenation/Acne Treatments

Informed Consent

This consent form is designed to provide the necessary information to decide whether or not to undergo laser or intense pulsed light (IPL) treatments (which will be referred to as “lasers”) for photorejuventation and for benign vascular and pigmented lesions.

There are several alternative methods to photorejuvenation, including but not limited to, topical skin products, liquid nitrogen for pigmented lesions, electrosurgery or sclerotherapy for facial vascular lesions, plastic surgery, or no treatment at all.

Laser treatments for photorejuvenation are indicated for skin conditions which include:

Telangiectasias (“spider veins”), redness and flushing symptoms of rosacea, brown spots, sun spots, lentigines (aging sun spots), dyschromia, melasma, enlarged pores, and acne. The lasers heat and eliminate the abnormal pigment in the skin and small blood vessels. Results vary and no guarantees can be made that a specific patient will benefit from treatment or achieve any level of improvement. **Maximum benefit is typically achieved with 3 to 6 treatments.**

Possible risks, side effects, and complications of laser treatments include, but are not limited to:

- Bruising, blistering, burns, scabbing, infection
- Hypopigmentation (lighter pigmentation) or hyperpigmentation (darker pigmentation)
- Scarring is rare, but can occur
- Reduced or no hair growth in treatment areas and adjacent areas
- Tattoos and permanent makeup in the treatment area may be altered
- Recurrent viral infections such as herpes simplex or varicella may be activated by treatments
- Minimal or lack of effect from the treatments

My signature below certifies that I have fully read this consent form and understand the information provided to me regarding the proposed procedure. I have been adequately informed about the procedure, including the potential benefits, limitations, and alternative treatments, and I have had all my questions and concerns answered to my satisfaction.

Patient Signature: _____

Or other Legally Responsible Person’s Signature: _____

Date: _____ **Time:** _____ ◯ **AM** ◯ **PM**

Witness Signature: _____

Date: _____ **Time:** _____ ◯ **AM** ◯ **PM**

I have explained to the patient or legal representative the disclosure and consent required for the medical, surgical, and/or diagnostic procedures planned as well as the patient’s right to withhold consent.

Physician’s Signature: _____ **Date:** _____

Notice of Privacy Practices

This is a summarized version of our Notice of Privacy Practices. The purpose of this form is to inform about how we may use and disclose your medical information. The Health Insurance Portability and Accountability Act (HIPAA) is a federal program requiring that all medical records used or disclosed by our office be kept confidential. We are required by law to maintain the privacy of your medical information and to provide you with notice of our legal duties and privacy practices.

HIPAA requires us to notify you that we may use your medical records for each of the following purpose:

Treatment
- Providing, coordinating, or managing your health care and related services.

Payment
- Obtaining reimbursement for services, confirming insurance coverage, billing, and collection activities and utilization review.

Health Care Operations
- Including business activities or management of our office.

You have the following rights regarding your medical records:
- You may request restrictions on disclosures of your medical records.
- You may review your medical records.
- You may request a copy of your medical record. There may be a charge for this service.
- You may provide an ammendment to your medical record.
- You may request a list of disclosures made from your medical record.

This summarized notice is effective as of 9/12/2013. We reserve the right to make modifications to our privacy notice. The complete version of our Notice of Privacy Practices is always available upon request. If you feel that your privacy protections have been compromised, you may contact our office manager or the Department of Health and Human Services or the Office of Civil Rights.

Patient Consent Form

HIPAA

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for [Insert practice name] to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).
(The Notice of Privacy Practices provided by Santa Cruz Med Spa describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Santa Cruz Med Spa reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Santa Cruz Med Spa, at 2030 North Pacific Avenue, Unit E, Santa Cruz, CA 95060.

With this consent, Santa Cruz Med Spa may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Santa Cruz Med Spa may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, Santa Cruz Med Spa may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that [Insert name of practice] restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Santa Cruz Med Spa to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Santa Cruz Med Spa may decline to provide treatment to me.

Signature of Patient or Legal Guardian _____

Print Patient’s Name _____ **Date** _____

Print Name of Patient or Legal Guardian, if applicable _____

Patient Information Handout

Laser Photorejuvenation Treatments

Prior to treatment

- Refrain completely from tanning and direct sun exposure for 4 weeks prior to each treatment and for the duration of your treatments.
- Avoid using sunless tanning products for 2 weeks before treatment.
- Discontinue use of glycolic acid and Retin-A containing products 1 week before treatments.
- Do not use medications that cause you to be sensitive to the sun for 72 hours prior to treatments. This may include medications, even over-the-counter ones. If you are taking any medications or supplements, discuss these with the provider before treatment.
- If you have a history of herpes or shingles in the treatment area, start your prescribed anti-viral medication 2 days prior to treatment and continue for 3 days after treatment.
- Consult your personal physician if there is a family or personal history of skin cancer or if you have skin lesions which have changed in any way, itched or bled recently.

After treatment

- Some skin redness and swelling are common and should resolve in a few hours to 3 days. Apply a wrapped ice pack to the treated areas for fifteen minutes every few hours as needed.
- Gently wash twice daily with mild soap. Do not rub the skin vigorously and avoid hot water.
- Avoid activities that cause flushing for 2–3 days after treatment, including consuming alcohol, exercise, extensive sun or heat exposure, swimming, hot tubs and Jacuzzis.
- Avoid irritants such as glycolic acid and retinoid products, toners, exfoliants, astringents, or other products that cause irritation for 1 week following treatment.
- If blistering, crusting, or scabbing develops, notify your physician then apply a thin layer of antibiotic ointment such as bacitracin to the area twice a day until the skin heals.
- Makeup can be worn once tlhere are no signs of skin irritation, usually the day after treatment. Use sunscreen dlaily with SPF 30 or greater for the duration of your treatments.
- Photorejuvenation treatments of pigmented lesions may initially look raised and darker. The lesions will darken over the next few days and flake off over 1–2 weeks.
- Photorejuvenation treatments of vascular lesions may disappear immediately, lighten or change color turning gray or bluish-purple. The lesions will usually lighten over the next week.

Consent Form

Consent to Photograph and Authorization for Use or Disclosure

Consent to Photograph:

I hereby consent to be photographed while receiving treatment at Santa Cruz Med Spa. The term "photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

Authorization for Use and Disclosure:

I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to Santa Cruz Med Spa, 2030 North Pacific Ave, Unit E, Santa Cruz, CA 95060.

Purpose:

I consent to be photographed and authorize the use or disclosure of such photograph(s) to be used in my medical records, for purposes of medical teaching, or for publication in medical photographs, assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold Santa Cruz Med Spa, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

Patient Rights:

- I may request cessation of filming or recording at any time.
- I may rescind this Authorization up until a reasonable time before the photograph is used, but I must do so in writing and submit it to Santa Cruz Med Spa.
- I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.
- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for any benefits.
- I have a right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such redisclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

I understand that I will not receive any financial compensation.

Signature

Date: _____ Time: _____ AM/ PM

Signature: _____

(patient/representative/spouse/financially responsible party)