



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)		



Disclosure and Consent

Nonablative Laser Treatments for Wrinkle Reduction

This consent form is designed to provide the necessary information to decide whether or not to undergo nonablative laser treatments for wrinkle reduction.

Lasers used for these treatments selectively heat up the collagen in the skin to stimulate new collagen synthesis. There is no break in the surface of the skin and there is little or no downtime associated with this laser treatment. Microdermabrasion is often done in conjunction with these laser treatments for improvement of superficial fine lines and pigment changes.

Results are cumulative and several treatments are typically required for maximum benefit. No guarantees can be made as to the results that might be obtained from these procedures, the percentage of improvement expected following treatments, or that a specific result will be achieved.

Other alternative wrinkle reduction treatments include microdermabrasion, chemical peels, laser resurfacing, surgery (such as facelifts), or no treatment at all.

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

- Hypopigmentation (lighter pigmentation) or hyperpigmentation (darker pigmentation)
- Herpes simplex (cold sores) or varicella (shingles) may be activated by treatments
- Tattoos and permanent makeup in the treatment area may be altered
- Burns, scarring

Patients with darker skin types have an increased risk of complications such as hypopigmentation, hyperpigmentation, burns, and scarring.

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. I understand and accept the risks, side effects, and possible complications inherent in undergoing nonablative laser treatments.

Patient Signature: _____

Or other Legally Responsible Person's Signature: _____ /

Relationship: _____

Date: _____ **Time:** _____ ()AM ()PM

Witness: _____ **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 amendment 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

Nonablative Laser Treatments for Wrinkle Reduction

Prior to treatment

- Refrain completely from tanning and direct sun exposure for 4 weeks prior to treatment and for 4 weeks after your treatments.
- Use sun block daily with zinc oxide or titanium dioxide (SPF 30 or greater) for the duration of your treatments.
- Discontinue use of glycolic and Retin-A containing products 1 week before treatments.
- Do not use medications that cause photosensitivity for 72 hours prior to treatments.
- 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.

After treatment

- Immediately after treatment, the skin may be red. This should resolve within a few hours.
- Makeup can be applied immediately after treatment.
- Avoid sun exposure and tanning for 4 weeks following treatment and use sun block daily with zinc oxide or titanium dioxide (SPF 30 or greater).
- Avoid activities that cause facial flushing, including vigorous exercise, consuming alcohol, extensive heat exposure, swimming and hot tubs for 1–2 days after treatment.
- Contact your physician immediately if blistering, crusting, or scabbing develops.
- Collagen formation will continue for 6 months and maximum benefit may not be noted for up to 6 months after completing treatments.



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)