NEW PATIENT PERSONAL INFORMATION

Please complete the following:

Date:____________________

Name:____

Address:____ City:_________________________

State:______ Zip:__________ Email Address:____

Contact Phone:____________________ Age:___________ ÁÁÁÁÁP^¸ Ápatient? Y or N

How were you referred?_________________________________ Have you had Botox before? Y or N

For our female clients: Are you pregnant or nursing? Y or N Using contraception Y or N

Please list all allergies (including medications, food, latex, cosmetics, lidocaine, sulfa, etc.)___________

____

Please list all medications, including herbal (esp. St John's Wort or Fish Oils)______________________

____

List all operations (including plastic/laser procedures), hospitalizations, and any serious illnesses:______

____

What are your concerns (please circle any of the following): unwanted hair, brown/red spots, wrinkles, lines, sagging skin, acne, blemishes, large pores, age spots, spider veins, scars, other (please list):____

Please check all that apply: ___insulin dependent diabetes ___high blood pressure ___cancer ___stroke ___blood clots ___bleeding problems with cuts or surgery ___jaundice or hepatitis ___very dry skin ___thyroid disease ___active skin disease or lesions ___dizziness, palpitations or fainting spells ___cold sores or fever blisters ___psychiatric disorder ___hormone imbalance ___herpes ___HIV/Aids ___scars/Keloids ___active infection ___vitiligo, scleroderma, lupus, hives ___unwanted tattoos or permanent makeup ___other

Please elaborate on checked items:____

Are you currently under the care of a physician? Y or N

Personal Physician:_________________________________ Phone #:_________________________

SKIP TO SIGNATURE IF NOT HAVING LASER

PLEASE COMPLETE THE FOLLOWING IF HAVING LASER TREATMENTS

Which of the following best describes your skin type after 1 hour of unprotected sun exposure? (please circle one skin type #)

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

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 irradiation? Y or N

Have you ever used Accutane? Y or N If yes, when?____

What topical medications or creams are you currently using? Retin-A, Renova, Rentinol? (others please list)____

Have you used any of the following hair removal methods in the past 6 weeks? { } shaving { } waxing

{ } electrolysis { } tweezing { } threading { } plucking { } depilatories

Have you had any recent tanning or tanning products that changed the color of your skin? Y or N

Do you form thick or raised scars from cuts, surgeries or burns? Y or N

Circle any of the following medications you have taken in the last 6 months (as they may increase hair growth or may be contraindications for laser treatments): birth control pills, androgens (Rogaine), Penicillin, cyclosporins, Minoxidil, steroids, Haldol, Phenytoin, thyroid medications, St John's Wort, Accutane, or Tetracycline

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, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures*.*

Signature:____ Date:_____________

I have (circle one) ***reviewed the medical history*** *or* ***reviewed the medical history and conferred with the patient****. I believe there are no contraindications to the planned aesthetic procedure.*

Physician Ç¦ÁÖ^|^*æe^ÁDÁSignature:______________________________________´ ÁÁÁÁÁÁÁÁÁÁDate:___________´

SPA IN THE CITY

Notice of Privacy Practices

Effective Date: August 1, 2011

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.

Protecting your privacy and maintaining the security of your protected health information is one of the most important responsibilities of this office.
If you have any questions about this notice, please contact our **Privacy Officer**.

Our Obligations

We are required by law to:

- Maintain the privacy of protected health information, hereinafter designated “PHI”.
- Give you this notice of our legal duties and privacy practices regarding your PHI.
- Follow the terms of our notice that is currently in effect.

How We May Use and Disclose Health Information

Except for the following, we will use and disclose health information only with your written permission:

- Treatment – We may use and disclose PHI for your treatment and to provide you with treatment-related services. For example, we may disclose PHI to doctors, nurses, technicians, pharmacists, including personnel outside our office who are involved in your care and need to provide you with care.
- Payment - We may use and disclose PHI so that we or others may bill and receive payment from you, from an insurance company, or a third party for the treatment and services you received.
- Operations – We may use and disclose PHI for operational purposes. These uses and disclosures are necessary to make sure that all of our clients receive quality care, and to operate and manage our office. For example, your PHI may be shared with quality improvement personnel to evaluate the performance of our staff.
- Appointment Reminders - We may use and disclose PHI to contact you and remind you of your appointment with us.
- Individuals Involved in Your Care or Payment for Your Care - We may use and disclose PHI with a person involved in your care such as your family or a close friend.
- Research - We may use your PHI for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI has approved the research.

Special Situations

- As Required by Law - We may disclose PHI when required to do so by international, federal, state, or local law.
- To Avert a Serious Threat to Health or Safety - We may disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

SPA IN THE CITY

Notice of Privacy Practices

Effective 8/1/2011

- Business Associates - We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your PHI and are not allowed to disclose any information other than as specified in our contract.
- Lawsuits and Disputes – We may disclose PHI in response to a court order or subpoena only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement - We may release PHI if requested by law enforcement official if the information is in response to a court order, subpoena, warrant, or summons.

Your Rights

You have the following rights regarding your protected health information ("PHI"):

- Right to Inspect and Copy – your medical and billing records. You must make this request in writing.
- Right to Amend – you may ask to amend the information when the information is in our office.
- Right to Accounting of Disclosures – you have the right to request a list of certain disclosures we made of your PHI other than for treatment, payment, operations, or disclosures with your written authorization. You must make this request in writing.
- Right to Request Restrictions – you have the right to request a restriction or limitation on the PHI we disclose for purposes of treatment, payment, operations, or to someone involved in your care or the payment of your care, like a family member or friend. For example, you may request that we not share information about a particular treatment with your spouse. This request must be made in writing. We are not required to agree to your request.
- Right to Request Confidential Communications - you have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request must be in writing and must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- Right to a Paper Copy of This Notice - You may ask us to provide you with a copy of this notice at any time.

Changes to This Notice

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. This notice will contain the effective date on the top of the first page.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Department of Health and Human Services, 200 Independence Ave., SW, Washington, DC 20201. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred. Filing a complaint will not interfere with your health care at this practice.

SPA IN THE CITY, LLC

Note: We are not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

Patient Name: ____ Date of Birth: ________

Patient Address: ____

____

Type of PHI to be restricted or limited: (please check all that apply)

___ Home Phone ___ Home Address ___ Occupation

___ Name of Employer ___ Visit notes ___ Cell Phone

___ Patient History ___ Office Address ___ Office phone #

___ Spouse's name ___ Spouse's office phone ___ Email Address

___ Other: ____

____

Please explain your restrictions – be specific.
How would you like use and/or disclosure of your PHI restricted? ____________________

____

____ __________________________
Signature of Patient Date

Original – file in patient chart

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I,_______________________________________

Have received a copy of the privacy practices of

SPA IN THE CITY

Signature:______________________Date:________