INTAKE FORM

Name: _____ **Date:** _____

How did you hear about Med Spa 22? _____

Date of Birth:_____ Age:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: (cell)_____(home)_____ (work)_____

May we leave a voice message? Yes _____ No _____ May we send mail? Yes _____ No _____

Email Address: _____

Appointment Confirmation: Text _____ E-Mail _____ Both _____

Medical History:

Allergies:_____

Medical History: _____

Medications: _____

History of Cold Sores, Fever Blisters or Herpetic Lesion	_____Yes _____No
History of Facial Paralysis	_____Yes _____No
Have you or a family member had Skin Cancer?	_____Yes _____No
Currently Pregnant or Breastfeeding	_____Yes _____No

Facial Cosmetic Concerns:

_____ Fine Lines and Wrinkles
_____ Folds and Lines Around Mouth
_____ Sagging and Loose Skin
_____ Uneven Skin Tone/Pigment/Melasma
_____ Redness / Capillaries / Rosacea
_____ Large Pores
_____ Unwanted Facial Hair
_____ Excessive Sweating
_____ Fat Bellow Chin, "Double Chin"
_____ Scarring
_____ Uneven Skin Texture
_____ Acne

Have you ever had the following treatments:

Botox / Dysport	___ Yes	___ No	Facial Surgery	___ Yes	___ No
Dermal Fillers	___ Yes	___ No	Microdermabrasion	___ Yes	___ No
Chemical Peels	___ Yes	___ No	Microneedling	___ Yes	___ No
Facial Laser	___ Yes	___ No	PRP	___ Yes	___ No

Do you go to a tanning salon? ___Yes ___ No **Do you use self-tanning products?** ___ Yes ___ No

Please check the skin characteristic that best describes your skin's response to sun exposure:

Characteristics / Fitzpatrick Scale:

____ Always Burns, Never Tans - Type 1
____ Usually Burns, Tans Less Than - Type 2
____ Sometimes Mild Burn, Tans Easily - Type 3
____ Rarely Burns, Tans More Than - Type 4
____ Rarely Burns, Tans Profusely - Type 5
____ Never Burns, Deeply Pigmented - Type 6

Treatments, Photography & Text Club

I authorize Med Spa 22 to perform treatments of elective cosmetic & minor skincare. I understand that I am financially responsible for services. I understand that Med Spa 22 has a 24-Hour cancellation policy. I also understand that if I fail to cancel or change my appointment, a charge may be applied. **(initial:_____)**

I authorize Med Spa 22 to take photographs of me and use them as an aid in my treatment, not to be shared publicly. I understand that these photographs will help document the progress of my treatment. I hereby authorize and consent to the about described photography. **(initial:_____)**

Texting Services: By agreeing to join the text club, I hereby expressly waive any claim against Med Spa 22, including claims against the corporation's officers and agents, related to, or stemming from, the text club service or any actions/omissions of the third party provider. **(initial:_____)**

Client Signature:_____ Date: _____

Reviewed By: _____ Date:_____

Consent and Notice of Privacy Practices

I understand the Health Insurance Portability and Accountability Act of 1996 (HIPPA) provides me certain rights to privacy regarding my protected health information.
I understand this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. The information may also be used to conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by this organization of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices from time to time and contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing a restriction of how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the facility is not required to agree to my requested restrictions, but if the facility does agree then they are bound to abide by such restrictions.

I understand I may revoke this consent, in writing at any time, except to the extent that the facility has taken action relying on my signed consent.

Patient Signature_____ Date _____

Witness Signature_____ Date _____

Copy to patient, Copy to patient file.