GLOW MEDSPA

---------- PATIENT INTAKE FORM ----------

Name (Last, First) _____, _____ Today's Date_____

Your Date of Birth: _____ Age: _____ Gender (please circle): *M* or *F*

Address: _____ Apartment # _____ or *N/A*

City: _____ State: _____ Zip: _____

Phone: Mobile: _____ Home: _____ Work: _____

Best number to leave any confidential information regarding your treatment and messages: (please circle) *Mobile* *Home* *Work*

E-mail address (please print clearly): _____

How did you hear about us? _____

Marital Status (please circle): *Single* *Married* *Widowed* *Divorced*

Occupation/Employer: _____ Hobbies/Activities: _____

Ethnicity (please circle): *Caucasian* *Hispanic* *African American* *Asian*

(Note: Ethnicity, national origin and race may affect how skin reacts to laser/IPL treatment)

Middle Eastern *Pacific Islander* *Other:* _____ *Prefer not to answer.*

Emergency Contact Name: _____ Relationship to you: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

---------- DETAILED MEDICAL HISTORY ----------

Skin Conditions (Psoriasis, Eczema, Scars, etc):	*NO*	*YES*	(If YES, explain) _____
Heart Disease (Heart Attack, Palpitations, etc):	*NO*	*YES*	(If YES, explain) _____
Neurological Disease (Seizures, Epilepsy, etc):	*NO*	*YES*	(If YES, explain) _____
Lung Disease (COPD, Asthma, etc):	*NO*	*YES*	(If YES, explain) _____
Liver/Kidney Disease (Cirrhosis, Hepatitis, etc):	*NO*	*YES*	(If YES, explain) _____
Cancer (Leukemia, Lymphoma, Melanoma, etc):	*NO*	*YES*	(If YES, explain) _____
Digestive Problems (IBS, Diarrhea, etc):	*NO*	*YES*	(If YES, explain) _____
Hypertension/Vascular disease (DVT, etc):	*NO*	*YES*	(If YES, explain) _____
Trauma (serious car accidents, injuries, etc):	*NO*	*YES*	(If YES, explain) _____
Infectious Disease (Tuberculosis, STDs, etc):	*NO*	*YES*	(If YES, explain) _____
Immunosuppression (HIV, AIDS, etc):	*NO*	*YES*	(If YES, explain) _____
Endocrine Disorder (Thyroid, Diabetes, etc):	*NO*	*YES*	(If YES, explain) _____
Mental Illness (Depression, Suicide, Bipolar, etc):	*NO*	*YES*	(If YES, explain) _____
Any OTHER medical problems:	*NO*	*YES*	(If YES, explain) _____

[OFFICE USE ONLY]

List ALL current MEDICATIONS: _____ List ALLERGIES: _____

[OFFICE USE ONLY]: _____ [STAFF SIGNATURE]:_____

(THIS DOCUMENT CONTINUES ON THE NEXT PAGE ➔)

GLOW MEDSPA

Do you have an allergy to Bacitracin®, Polysporin®, Neosporin® or any other topical antibiotic cream? *NO* *YES*

Do you have an allergy to any topical anesthetics such as Benzocaine, Tetracaine or Lidocaine? *NO* *YES*

Have you used Accutane®, Claravis®, Sotret® or Amnesteem® (Isotretinoin) in the last six months? *NO* *YES*

Do you have a history of herpes simplex ("cold sores" or "fever blisters") or infection in area to be treated? *NO* *YES*

Female patients only: Are you pregnant or breast-feeding? *NO* *YES*

Female patients only: Do you take any kind of birth control? *NO* *YES*

Last Sun Exposure (tanning / outdoor activity): _____

Do you use tanning beds or spray-on tanning? *NO* *YES* Last exposure: _____

Do you smoke? *NO* *YES* If YES, how much and how often? _____

How does your skin react when exposed to the sun? (please circle only ONE of these six choices below)

Always Burns & Never Tans	Burns Easily & Tans Minimally	Sometimes Burns & Slowly Tans	Burns Minimally & Usually Tans	Rarely Burns & Tans Well	Never Burns & Always Tans

---------- for HAIR REDUCTION patients only ----------

Which body areas are you interested in having hair reduced? _____

Have you had previous laser hair reduction treatments? *NO* *YES* _____

Has your skin or hair changed in any way recently? *NO* *YES* _____

Why do you want hair reduction treatment? _____

Please describe the hair you want treated: _____

Are you currently using a retinol or retinoid (Retin-A®, Tretinoin, Renova®, Tazorac®, Differin®) or glycolic acid? *NO* *YES* _____

WHAT AREAS ARE YOU INTERESTED IN RECEIVING LASER HAIR REMOVAL TODAY?

_____ Full Body	_____ Mid brow	_____ Shoulder Caps
_____ Face	_____ Nose	_____ Side Burns
_____ Brazilian	_____ Cheeks	_____ Areolas
_____ Brazilian Extended	_____ Chin	_____ Belly Line
_____ Legs	_____ Ears	_____ Bikini Line
_____ Arms	_____ Hairline	_____ Buttocks
_____ Back	_____ Forehead	_____ Elbows
_____ Chest	_____ Scalp	_____ Knees
_____ Abdomen/Full Belly	_____ Beard Line	_____ Inner Thighs
_____ Hands and Fingers	_____ Back of Neck	_____ Underarms
_____ Feet and Toes	_____ Front of Neck	

---------- for NAIL FUNGUS REMOVAL patients only ----------

Number of years infected? _____

Any problems with the area besides this? NO YES _____

What other medications, prescription or over the counter have you used? NONE or names of medication _____

What are you currently doing at home (home remedies)? NONE or _____

Have you seen a physician in the past about this matter? NO YES _____

(THIS DOCUMENT CONTINUES ON THE NEXT PAGE ➔)

Please circle the Skin Type that matches your features and Reaction to UV (30 minutes of sunlight without SPF)

Skin Type	Common features	Reaction to UV*
I	Very fair / blue eyes / freckles	Always burns, never tans
II	Fair / blue, hazel or green eyes	Always or usually burns, tans with difficulty, tan fades rapidly
III	Cream white / fair with any eye or hair color / very common	Sometimes mild burn, always or usually tans, tan stays for weeks
IV	Brown / typical Mediterranean skin / moderately pigmented and may include Asian, Middle Eastern, Indian, Hispanic	Rarely burns, tans with ease, tan stays for months
V	Darker brown / darker skin type and may include Asian, Middle Eastern, Indian, Hispanic, Mediterranean (non Caucasian)	Very rarely burns, tans very easily
VI	Darkest brown, black (non Caucasian)	Never burns, tans very easily

Adapted from Fitzpatrick TB
The Validity and Practicality of Sun-Reactive Skin Types I through VI
Arch Dermatol-Vol 124, June 1988.

Are there any other services that you are interested in?

Injectables:

- □ Botox/Dysport
- □ Fillers

Lasers:

- □ Laser Hair Removal
  What area of the body? _____
- □ Laser Nail Fungus Removal
- □ Laser Sun Spot Removal

Skin Services:

- □ Microneedling
- □ Dermaplanning
- □ Chemical Peel
- □ Facial Services

What are your skin concerns?

- ____ Acne
- ____ Discoloration/ Uneven Skin Tone
- ____ Hyperpigmentation / Sun damage
- □ ____ Fine lines/ wrinkles
- ____ Texture
- ____ Rosacea
- ____ Dryness
- ____ Other:_____

GLOW MEDSPA

---------- POLICIES, PROCEDURES, AGREEMENTS and CONSENTS ----------

The next two pages are intended to provide you with detailed information about our policies, programs, agreements and consents. Please read each section thoroughly, make sure any concerns are addressed and that any questions you have are answered before making your final decision to move forward with the treatment process.

----------HIPAA PATIENT CONSENT----------

- Our office is committed to protecting the privacy of your medical information. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and updated in 2013) is a federal law that governs the use and disclosure of a person's health information. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. The Notice contains a "Patient Rights" section describing your rights under the law. The following statements cover the basics of your rights as a patient under HIPAA:

- Our office has a "Notice of Privacy Practices" and you have the right to review a detailed copy of our Notice before signing this HIPAA Patient Consent.
- This "Notice of Privacy Practices" is available in our offices.
- Protected health information may be disclosed for treatment, payment, or health care operations.
- We reserve the right to change the terms of our "Notice of Privacy Practices" at any time.
- If we change our Notice, you may obtain a revised copy by contacting our office.
- You have the right to restrict the uses of your protected health information.
- You may revoke this HIPAA Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Additionally, it is the policy of this office to remind patients of their appointments. We may do this via live telephone calls, automated (TeleVox) appointment reminder calls, text messages, e-mails, U.S mail, social media or by any means convenient to the practice. We may also send you other communications informing you of changes to office policy, new technology and specials that you might find valuable or informative. That said, contact will only come directly from us; we will never sell or trade your private information including phone numbers, e-mail address or mailing addresses. You may opt out of any or all communication measures any time by contacting us in writing.

By signing the next page of this document, you certify that you have read our HIPAA Patient Consent and have had the opportunity to review a more detailed version if so desired. Your signature also signifies that you agree with the above statements and this policy. GLOW MEDSPA provides this form and information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (updated in 2013).

--- TELEHEALTH (TELEMEDICINE) CONSENT and VIDEO/PHOTO AGREEMENT ---

My signature below certifies that I understand, agree and consent that GLOW MEDSPA and its employees, independent contractors, associates, agents and representatives (collectively and hereby known as, "GLOW MEDSPA",) may take photographs and/or use video (for "store & forward" or teleconferencing technology) of the area to be treated before initial treatment begins & at some or all reoccurring visits (genital area photos and videos are usually NOT taken). These recordings will be available only to our medical staff members to assess the patient and track the progression of each treatment and are part of the medical record. GLOW MEDSPA follows extremely strict HIPPA guidelines regarding patient confidentiality and privacy & therefore names and recordings are used internally and only the treated area/area to be assessed will be shown in these photographs & videos.

Print Patient Name: _____

Patient Signature: _____ Date: _____

(THIS SHEET CONTINUES ONTO THE NEXT PAGE)

GLOW MEDSPA

---------- APPOINTMENT POLICY ----------

GLOW MEDSPA strives to treat all clients at their scheduled times. Keeping your appointments allows for better results because you are able to stay on your hair growth schedule. Additionally, no-shows block out otherwise available slots for other clients to get in to stay on their treatment schedules. Clients must provide 24 hours notice if they need to reschedule or are unable to make their appointment.

- Clients must pay a $25.00 “no show” / “late cancellation” fee if they miss an appointment or do not give 24 hours notice of a cancellation or re-schedule.
- If the provided credit card declines, Glow Medspa will penalize by applying the treatment areas scheduled on the day of the no-show as used.

***As a courtesy to our clients we try to send out email and text reminders. However, not receiving those reminders will not excuse a missed appointment.**

Please choose Option 1 or Option 2

Option 1: Your credit card information can be encrypted and stored with our credit card processor in a very secure manner. Even Glow Medspa won’t have access to the card’s information. Glow Medspa will only be able to charge it for no show fees and purchases if you decide to use it in the future. For this option, please hand your card to the front desk coordinator and we will get the information added and stored securely.

Option 2: You can fill out the information below and we will keep your card info in your file.

Name of Client: _____Name on Credit Card:_____

Card Type (circle one): VisaMastercardAmEx Discover

Credit Card #: _____ Expiration Date: _____

My signature below indicates that I understand Glow Medspa Hair’s no-show policy and that I authorize my credit card to be charged in accordance with the terms of the policy should I be in violation of these terms.

---------- FINANCIAL RESPONSIBILITY POLICY ----------

My signature below certifies that I hereby seek the services of GLOW MEDSPA, and its employees, independent contractors, associates, agents and representatives (collectively and hereby known as, “GLOW MEDSPA ”,) for laser, collagen induction therapy and/or dermatological care. I understand that microneedling and laser treatments, such as hair reduction, are voluntary procedures and are not covered by Medicare, Medicaid, Medi-Cal, HMO, PPO, or private insurance plans. I understand that GLOW MEDSPA will not submit any claims to any insurance carriers. I understand that payment is due before services are rendered. I also understand and agree that if I pay for a package of services using a credit card, check or finance company and the payment is not honored or is subject to a chargeback at any time for any reason that I am still fully responsible for payment for the treatments I receive and agree to pay for them at the undiscounted (“pay as you go”) rate. I agree to pay a fee of $25.00 for each check or charge that is not honored by my bank. Lastly, I fully acknowledge that I am personally responsible for all fees and charges incurred in connection with my purchase and I completely understand that there is absolutely **NO** refunding of any patient fees, payments, charges, credit, gift certificates, product purchases or pre-paid packages.

✖ _____	✖ _____
PRINTED NAME OF PATIENT	**TODAY’S DATE**
✖ _____	
PATIENT SIGNATURE (or signature of legal guardian if patient is under 18)	This space for office use only (Staff Signature)