NEW PATIENT FORM

Patient Name: Date:

( ) M ( ) F

Occupation: Birth Date:

Address:

City: State: Zip:

Cell Phone: Home Phone:

Work Phone: Email:

Emergency Contact: Phone Number:

Physician Name: Phone Number:

Employer: Phone Number:

Primary Healthcare Provider:

How did you hear about us (check all that apply)? Friend_____ Relative_____ Web Search_____ Newspaper_____ Radio _____ Facebook_____ Television _____ Email_____

What brings you to Starwood Med Spa?

PREVIOUS PROCEDURES Which of the following have you had in the past?

- ☐ Coolsculpting
- ☐ Fillers (Juvederm/ Radiesse/Restalyne/Voluma)
- ☐ Chemical Peels
- ☐ Electrolysis
- ☐ Tattoo Removal
- ☐ Permanent Make-Up
- ☐ Skin Rejuvenation
- ☐ Cellulite/Circumference
- ☐ Botox
- ☐ Microdermabrasion
- ☐ Facials
- ☐ Waxing/Threading
- ☐ Laser Hair Removal
- ☐ Skin Resurfacing
- ☐ Skin Tightening
- ☐ Reduction

Client Initials: _________

Staff Review: ___________

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:

Your protected health information will be used, as needed, to obtain payment for your services.

Healthcare Operations:

We may use or disclose, as-needed, your protected health information in order to support the business activities of our and / or your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of new employees and/or medical students, and licensing board. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when we're ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Workers' Compensation: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures:

Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization:

You may revoke permission at any time, in writing.

Your Rights:

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information:

Under federal law, however, you may not inspect or copy the following records; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information:

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices, unless specifically requested and annotated by Patient. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications:

You may request to receive information from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician and / or Starwoods's physician amend your protected health information:

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures:

Any disclosures we have made, if any, of your protected health information: We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

____ __________________

Patient name and Signature Date:

PATIENT RIGHTS AND RESPONSIBILITIES

We are committed to serving you with compassion, care, and respect. As one of our valued clients you are entitled and have the right to the following:

- To be treated with respect and dignity.
- To know the names and professional status of the person(s) serving you.
- To privacy and confidentiality.
- To receive accurate information about your health-related concerns.
- To know the effectiveness and potential side-effects of all forms of treatment.
- To receive education and counseling about treatments.
- To review your medical record and to amend your records.

You have the responsibility:

- To seek medical attention promptly when there is a possibility of an emergency, and to provide useful feedback.
- To be honest about your medical history, any possible skin condition, and sun exposer.
- To ask questions about anything you do not understand.
- To follow health advice and instructions.
- To report any significant changes in your health.
- To respect clinic policies and staff.
- To show up to appointments or cancel 24 hours in advance.

Authorizations:

- I authorize Starwood to perform the treatment or procedures recommended. Initial: _____
- I acknowledge no guarantee; either expressed or implied has been made to me regarding the outcome of any treatment or process; nor can anyone know the exact outcome of any treatment or process. Initial: _____
- I understand I am financially responsible for all procedures due when services are rendered, and for any appointment I fail to attend without 24 hours' notice, and/or be charged a fee and/or lose a treatment. It must be a full 24 hours before the scheduled treatment time. Initial: _____
- I authorize the release of information to: a licensed physician of the facility's choosing for the purpose of professional interpretation and establishment of their recommendations. Initial: _____

Patient Signature: ____ Date: _________________

Reviewed by: ____ Date: _________________

CANCELLATION POLICY

MED SPA AND HEALTH AND WELLNESS APPOINTMENTS

- Starwood Med Spa requires a **24 hour notice** to cancel or reschedule an appointment.
- For all appointments, credit card information is required to be kept on file. In the event you miss a scheduled appointment and/or do not cancel your appointment prior to 48 hours, and/or an 'unapproved' cancellation, your card will be charged a $50 "No Show" Fee.
- If you arrive more than ten minutes late for your scheduled appointment, it will be considered a "No Show". At that time, your card will be charged the $50 'No Show' fee. Provision of services for late appointments will be at Starwood's discretion.
- If a client has excessive no shows or last minute cancellations, Starwood reserves the right to refuse further service regardless of contracts or other set appointments. Any monies paid will be forfeited or considered non-refundable.

I agree and understand Starwood Med Spa cancellation policy.

Client Name (Print): ____________________________________ Date: _____________

Client Signature: _____________________________________ Date: _____________

Please answer ALL of the following questions to the best of your ability. Be as open and honest as you can so that we may better meet your needs. Information is Confidential.

MEDICAL HISTORY

Please make explanations on MEDICAL AND SURGICAL HISTORY FORM

	YES	NO
1. Do you have ANY chronic medical conditions? Please list below	y	n
2. Do you have a history of cold sores, fever blisters, shingles, and/or Herpes 1—genital, and/or Herpes 2—simplex?	y	n

What kind of outbreak, and when last?

____

3. Have you ever had cancer?	y	n
4. Do you suffer from HIV / AIDS?	y	n
5. Do you have Hepatitis? What kind?	y	n
6. Do you have a history of poor healing?	y	n

List: ____

ALLERGIES

Please make explanations on MEDICAL AND SURGICAL HISTORY FORM

	YES	NO
1. Do you have ANY allergies OR sensitivities to medications, herbal and/or natural supplements, chemicals, food and/or sunlight?	y	n

Please name them, and the kind of reaction you have to them:

______________ ______________ ______________

______________ ______________ ______________

2. Do you suffer from Eczema?	y	n
3. Anything further Starwood Med Spa should know about your allergies including ANY life threatening allergies to anything?	y	n

____

MEDICATION HISTORY

Please list ANY medications / supplements / herbs on MEDICATION SHEET, as well as any creams, lotions. Anything you put in or on your body at any place.

	YES	NO
1. Do you have or have you used any topical medications or creams, such as, Retin—A, Renova, Tazorac; Differin, Glycolic Acid, Obagi, or any other similar product?	y	n
2. Are you currently taking any antibiotics?	y	n

3. Have you taken Accutane in the past 6 months?	y	n
4. Are you on any anticoagulants or blood thinner medications, including aspirin, ibuprophen, or any other NSAIDs?	y	n
5. Do you smoke? How many cigarettes / packs a day? ______________________________	y	n

6. Do you drink alcoholic beverages? yes No How often? ____________________

7. Do you use recreational drugs? yes no How often? ____________________

ENDOCRINE SYSTEM—HORMONE ISSUES

	YES	NO
1. Do you have a history of Thyroid imbalance?	y	n
2. Do you have an auto immune disorder? (e.g. Lupus, Rheumatoid Arthritis, Scleroderma)	y	n
3. Do you have Diabetes?	y	n
4. Have you had an increase in the amount of hair you normally have?	y	n
5. Do you have any hormone issues? Are you on any hormone supplements?	y	n

Any other issues Starwood Med Spa should be aware?

WOMAN ONLY

Comments:
____
____
____

Are you currently breastfeeding?	y	n
Are you or could you be pregnant?	y	n
Are your menstrual cycles normal?	y	n
Are in menopause?	y	n

SKIN & HAIR HISTORY

What are you skin care goals? ____________________

1. Do you have an active skin infection? Please tell us about it.	y	n
2. Have you had ANY hair removal procedures including: Plucking, tweezing, waxing, electrolysis, or depilatory creams in the last 4 weeks?	y	n
3. Do you have any moles that have recently changed, itched, or bled?	y	n
4. Have you had exposure to the sun, used a tanning bed 4-6 weeks or spray tan last 2 weeks?	y	n
5. Do you use sun screen daily with SPF 30 or higher—block for UVA and UVB rays?	y	n
6. Do you have any scars on the face?	y	n

7. Do you have permanent make-up or tattoos? Location: ______________________________ y n

8. List any cosmetic treatments you have undergone, such as: Laser; Microdermabrasion; chemical peel; radio frequency (RF); cosmetic injection; Intense Pulse Light (IPL), other

__________________________________ __________________________________ __________________________________

9. What skin care products do you currently use?

__________________________________ __________________________________ __________________________________

Please circle all that apply:

Acne	Broken Capillaries	Dry
Enlarged Pores	Hyper-pigmentation	Hypo-pigmentation
Keloid Scarring	Melasma	Oily
Rash	Scarring	Stretch Marks

Any other Skin condition or concern you feel we should be aware:______________________________

Your Skin Score	Query	0	1	2	3	4
	What is your eye color?	Light Blue or Gray	Blue or Green	Hazel or Light Brown	Dark Brown	Brownish Black
	What is your natural hair color?	Red, Sandy Red	Blonde	Dk Blonde, Chestnut, Brown	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful, redness, blistering, and peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burn	Never burn
	To what degree do you turn brown?	Hardly or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never has problems in the sun
	TOTAL					
	Scoring Skin Type:	0-7—I	8-16—II	17-25—III	26-30—IV	Over 30—V - VI