# Calvine Medical Aesthetics

(PLEASE PRINT)

Name: ______________________________________________________________
LAST FIRST MIDDLE

Home Address: ________________________________________________________
STREET

City: ________________________________State:______________Zip:_____________

Home phone: (      )______________________Work phone: (      )______________________

Cell phone: (      )__________________E-mail: _____________________________________

How do you wish to be contacted? _____________________________________________

Birth Date: ____________________Sex:___________
mm/dd/yyyy

How did you hear about us? __________________________________________________

**Emergency Contact**

Name: ______________________________________Relationship: ______________________

Home phone: (      )_____________Work: (      )_____________Cell: (      )______________

**Signature:** _______________________________________**Date:** _______________________

**Parental Signature (If under the age of 18)**:________________________________________

Due to the HIPAA (Health Insurance Portability and Accountability Act) all information must be completed on this form and the following forms. If you have any questions regarding this, anyone in our office will be glad to help you.

Thank you for choosing Calvine Medical Aesthetics

# CALVINE MEDICAL AESTHETICS

***I authorize Calvine Medical Aesthetics to perform laser cosmetic treatments on me, including but not limited to: deep tissue heating, treatment of pigmented lesions, vascular lesions, and/or wrinkles. I understand that this procedure is purely elective, that the results vary with each individual, and that multiple treatments may be necessary to achieve desired results. Please initial after reading each statement.***

**I understand that:**

- **I must arrive at least 10 minutes prior to my scheduled appointment time.________**
- **There is a 24 hour cancellation/late arrival policy. If miss my appointment, cancel or change my appointment (which includes late arrival) with less than 24 hours notice, I forfeit my appointment at the discretion of the laser nurse providing the service. If you are late more than 15 minutes, you appointment will be cancelled and you will have to re-schedule. __________**
- **If you cancel an apt less than 24 hours in advance you will be charged the $25 service fee. In order to book your next apt and resume any further treatments, you must pay the $25 service fee_________**
- **Children are NOT allowed in the treatment room. Calvine Urgent Care employees are NOT responsible for your children. __________**
- **Serious complications are rare, but possible. _________**
- **Common side effects include temporary redness and a mild "sunburn" like affect that may last a few hours to 3-4 days or longer. _________**
- **Pigment changes, including hypo pigmentation (lightening of the skin) or hyper pigmentation (darkening of the skin), lasting 1-6 months or longer may occur. _________**
- **Freckles may temporarily or permanently disappear in treated areas. _________**
- **Other potential risks include crusting, itching, pain, bruising, burns, infection, swelling, and failure to achieve the desired result. _________**
- **Lasers can cause eye injury and protective eyewear must be worn during treatments. _________**
- **I understand that sun or tanning bed exposure (including self tanning lotions) and not adhering to the post-care instructions provided to me, may increase my chances of complications. _________**
- **I am not pregnant, using systemic steroids, have discontinued use of Accutane for at least 6 months, have a blood disorder, or have a history of keloid scarring. ______**

**I have read all of the above statements. The before and after treatment instructions have been discussed with me, the procedure as well as potential benefits and risks have been explained to my satisfaction, and my questions have been answered. I freely consent to the proposed treatment, and understand and agree to the above statements.**

**Patient's Signature________________________________________________________Date__________________**

**Provider's Signature_______________________________________________________Date__________________**

# Fitzpatrick Skin Type Worksheet

Name: Date:

| Score | | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| | What is the color of your eyes? | Light Blue, Gray or Green | Blue, Gray, or Green | Blue | Dark Brown | Brownish Black |
| | What is your natural hair color? | Sandy Red | Blond | Chestnut, Dark Blond | Dark Brown | Black |
| | What is the color of your unexposed skin? | Reddish | Very Pale | Pale with Beige Tint | Light Brown | Dark Brown |
| | Do you have Freckles on Sun exposed areas? | Many | Several | Few | Incidental | None |
| | What happens when you stay in the sun to long? | Painful Redness, Blistering, Peeling | Blistering Followed | Burns sometimes followed by Peeling | Rare Burns | Never had Burns |
| | To what degree do you turn Brown? | Hardly or Not at all | Light color Tan | Reasonable Tan | Tan Very Easily | Turn Dark Brown Quickly |
| | Do you turn brown several hours after sun exposure? | Never | Seldom | Sometimes | Often | Always |
| | How does your face respond to the Sun? | Very Sensitive | Sensitive | Normal | Very Resistant | Never had a Problem |
| | When did you last expose yourself to the sun tanning bed or self-tanning creams? | More than 3 Months ago | 2-3 Months ago | 1-2 Months ago | Less Than 1 Month ago | Less than 2 Weeks ago |
| | Do you expose the area to be treated to the sun? | Never | Hardly Ever | Sometimes | Often | Always |

| Total Score: / Skin Type: | Score | Fitzpatrick Skin Type: |
|---|---|---|
| | 0-7 | I |
| | 8-16 | II |
| | 17-25 | III |
| | 26-30 | IV |
| | Over 30 | V-VI |

Comments:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Signature: ______________________________ Date:______________

# *Medical Spa Profile and Assessment Tool*

**Patient Name: ___________________________________________ Date: ________/________/___________**

***We ask that all clients complete this profile prior to receiving any service. We use this information to accurately evaluate our client's specific needs. This information is completely CONFIDENTIAL and used for analysis purposes only.***

**1. Do you have any health issues?** Check all that apply

[ ] Back/Spinal Problems
[ ] Blood Clots
[ ] Heart Problems
[ ] Pregnant or Lactating
[ ] Blood Pressure
[ ] Bruise Easily
[ ] Hormone Imbalance
[ ] Skin Sensitivity
[ ] Diabetes
[ ] Epilepsy/Seizures
[ ] Rosacea
[ ] Claustrophobia
[ ] Thyroid (over/underactive)
[ ] Implants (pacemaker, pins in bones, etc.)
[ ] Cancer: ______________
[ ] Other Skin Problem:____________________
[ ] Allergies/Sensitivities
[ ] HIV/AIDS

**2. Do you experience these conditions on your skin?**

[ ] Flakiness
[ ] Tightness
[ ] Bruising
[ ] Oiliness
[ ] Breakouts
[ ] Redness

**3. Are you using acne/aging products? (oral/topical)**

[ ] Retin-A
[ ] Renova
[ ] Accutane
[ ] Differin
[ ] Azelex
[ ] Other:_____________________

**4. Have you ever had a reaction to any of the following?**

[ ] Shellfish/Iodine
[ ] Medicine
[ ] Make up
[ ] Sunscreens
[ ] Fragrance/Dyes
[ ] AHA's
[ ] Other:________________________________________

**5. Have you been under a physicians care recently?**

[ ] Yes [ ] No
[ ] If yes, for what?________________________________

**6. Do you sun bathe or use tanning beds?**

[ ] Yes [ ] No

**7. Are you using oral contraceptives?**

[ ] Yes [ ] No

**8. Do you use sunscreen?**

[ ]Yes [ ] No

**9. Have you had microderms or chemical peels?**

[ ] Yes [ ] No

**10. Do you smoke?**

[ ] Yes [ ]No

**11. Do you follow a specialized diet?**

[ ] Yes [ ] No

**Do you exercise regularly?**

[ ] Yes [ ] No

**13. List any meds/supplements you're taking:**

________________________________________

**14. What skin care program are you using?**

______________________________________

**15. Have you started new meds, treatments, or skin care products recently? If yes, specify:**

_______________________________________________
_______________________________________________
_______________________________________________

**16. Please list recent surgeries, hospitalizations, major illnesses and accidents. (Include dates)**

____________________________________________
____________________________________________
____________________________________________

***I confirm that to the best of my knowledge, the answers I have given are correct and I have no withheld any information. I will inform my practitioner of any changes in my health of lifestyle which may affect my treatments.***

**Client Signature: _________________________________________________________ Date: ________/________/___________**

**We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. This notice describes our policies related to the use of the records of your care and how you may get access to this information.**

***Use and Disclosure of Protected Health Information.*** In order to effectively provide care, there are times when we will need to share your personal health information with others beyond the urgent care practice for:
**Treatment.** With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside of the urgent care practice that we are consulting with or
**Payment.** Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.
**Operations.** We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, and training staff.
***Information Disclosed Without Your Consent.*** Under state and federal law, information about you may be disclosed without your consent in the following circumstances:
**Emergencies.** Sufficient information may be shared to address the immediate emergency you are facing.
**Follow Up Appointments/Care.** We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
**As Required by Law.** This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.
**Governmental Requirements.** We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.
**Criminal Activity or Danger to Others.** If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.
***PATIENT RIGHTS AND RESPONSIBILITIES*** You have the following rights under state and federal law:
**Copy of Record.** You are entitled to inspect the personal health record we have generated about you. We may charge you a reasonable fee for copying and mailing your record.
**Release of Records.** You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.
**Restriction on Record.** You may ask us not to use or disclose part of the personal health information. This request must be in writing. We are not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information.
**Contacting You.** You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct.
**Amending Record.** If you believe that something in your record is incorrect or incomplete, you may request we amend it. Your request should be made in writing. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.
**Accounting for Disclosures.** You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. We will notify you of the cost involved in preparing this list.
**Questions and Complaints.** If you have any questions, or wish a copy of this policy or have any complaints you may contact us in writing for further Information. You also may complain to the Secretary of Health and Human Services if you believe this practice has violated your privacy rights. We will not retaliate against you for filing a complaint.
**Changes in Policy .** This practice reserves the right to change its Privacy Policy based on the needs of the practice and changes in state and federal law.

Read all sections before signing**.**

**IMPORTANT: I acknowledge that I have received and read this privacy notice.**

Signature ____________________________________________Date_____________________