PATIENT INFORMATION FORM

PLEASE PRINT LEGIBLE

Patient Name: _____ **DOB & Age:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Preferred Language _____ **Race:** _____

Sex: _____ **Email Address:** _____

Employer Name: _____

Occupation: _____ **Work Phone:** _____

How did you hear about us? _____

Pharmacy Name & Number: _____

Emergency Contact

Name: _____

Relationship: ☐ **Spouse** ☐ **Parent/Guardian** ☐ **Other:** _____

Phone: _____

Payment Agreement

I, _____, understand that payment is due when services are rendered. I agree that all unpaid balances are subject to collection fees, which also is my responsibility. I hereby authorize release of my information necessary to secure payment.

ALL SKINCARE PRODUCT SALES WILL BE <u>FINAL</u>. If you have an allergic or adverse reaction please call our office so it can be documented.

_____ _____

Patient Signature Date

The Bloom Medical Spa

CONSENT TO COMMUNICATE

Patient Name: _____

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐
☐ Send Email	-	-	☐
☐ Would you like to receive our specials via email?	-	-	

Patient Signature: _____ **Date:** _____

APPOINTMENT NO SHOW & CANCELLATION POLICY

Our goal is to provide quality treatments in a timely manner to all our patients. In order to do so we have had to implement an appointment "No Show" and same day cancellation policy. When a patient does not keep their reserved appointment, another patient loses the opportunity to be seen.

While we understand that unplanned issues can arise and you may need to cancel or re-schedule an appointment, we respectfully ask that you call us at least 24 hours in advance. This will enable us to better utilize available appointments for all of our patients.

You may call our office during regular office hours between 9am & 5pm, Monday through Friday to make changes to your scheduled appointment. **Please make note – our answering service cannot make changes to your appointment or take messages of the need to cancel, they only handle emergency calls. All changes must be made with our office staff to avoid any confusion**.

As of September 1, 2013, a fee of **$50.00** will assessed if we do not receive a call at least 24 hours prior to your appointment time to cancel or re-schedule.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy.

By signing below, I acknowledge that I have read and understand this policy.

Patient Signature: _____ **Date:** _____

Print Name: _____

Witness: _____ **Date:** _____

HIPAA Information and Consent Form

Patient Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

The Bloom Medical Spa

MEDICAL & PAST TREATMENT HISTORY

Patient Name: _____

Reason for Consultation Today: _____

MEDICAL HISTORY	Yes	No	Description
Latex sensitivity	☐	☐	
Cold sores / fever blisters	☐	☐	
High or Low Blood Pressure ***(PLEASE CIRCLE)***	☐	☐	
Breathing problems / Asthma / COPD ***(PLEASE CIRCLE)***	☐	☐	
Hepatitis	☐	☐	
Shingles	☐	☐	
HIV +	☐	☐	
Excessive or Easy Bleeding / Blood Thinners ***(PLEASE CIRCLE)***	☐	☐	
Bruise Easily	☐	☐	
Heart Attack / Heart Problems / Pacemaker ***(PLEASE CIRCLE)***	☐	☐	
Diabetes	☐	☐	
Are you a current or former smoker? ***(PLEASE CIRCLE)***	☐	☐	

PAST TREATMENT HISTORY

NEUROTOXINS: ☐ Botox ☐ Dysport ☐ Xeomin

DERMAL FILLERS: ☐ Restylane ☐ Perlane ☐ Juvederm ☐ Voluma ☐ Sculptra ☐ Radiesse ☐ Belotero ☐ Artefill

LASERS & OTHER TREATMENTS: ☐ Photofacial (IPL/BBL) ☐ Venus Freeze or Legacy ☐ Laser Resurfacing

Past Cosmetic Surgery including any facial implants (please list): _____

Have you taken Accutane, anticoagulants, or sun sensitive medications within the last 6 months? ☐ YES ☐ NO

Please list any skin care products that you use, including Retin-A, Glycolics, Bleaches, Corticosteriods, etc

Please list **ALL** medications that you are presently taking, including prescriptions, over the counter medications, vitamins, herbals, birth control, etc:

Please list any known or perceived allergies or sensitivities that you have had to any medications along with the type of reaction you have experienced:

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ **Date:** <Appointment.Date>

Provider Reviewed: _____ **Provider:** _____