Client Intake

Name: _____ Date of Birth: _____ Sex:_____

Email (Please Print) _____

Address: _____ City: _____ State: _____

Zip:_____ Home Phone: _____Cell: _____

Work: _____ Emergency Contact: _____ Phone: _____

May we send text/email reminders Yes No

May we send text/emails for specials/events Yes No

How did you hear about us? (Please circle all that apply)

Friend Relative Web Google Facebook Instagram *Did a current patient refer you? Y N*

Tell us their name and we will give you and them $25 Referral dollars _____

SKIN CARE/What is your daily skin care regimen? _____

Which of the following best describes your skin type?

□ Combination skin (oily in T-zone, dry to normal cheeks) □Oily skin □Very oily skin, large pores
□ Sensitive skin □ Dry skin

SUN HISTORY & LIFESTYLE

How often do you work outdoors?	□ Frequently	□ Occasionally	□ Very Rarely
How often do you use a sunscreen?	□ Frequently.	□ Occasionally	□ Very Rarely
How often do you use tanning beds?	□ Frequently	□ Occasionally	□ Very Rarely

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

□ Botox
□ Fillers
□ Chemical Peels
□ Electrolysis
□Waxing/Threading
□ Skin Tightening
□ Skin Resurfacing
□ Tattoo Removal
□ Microdermabrasion
□ Skin Rejuvenation
□ Cellulite Circumference Reduction
□ Laser Hair Removal

INTERESTS: *What would you like to learn more about?*

□ Fine lines/Wrinkles
□ Volume Loss/Deep Lines
□ Skin Care
□ Age Spots/Sun Damage
□ Flushing of the Skin
□ Acne
□ Acne
□ Acne Scar Reduction
□ Large Pores
□ Crow's Feet
□ Stretch Marks
□ Chemical Peels
□ Laser Hair Removal
□ Spider Vein Reduction
□ Skin Texture/Scars
□ Pigmented Lesions

Reviewed By _____**Date** _____

Client _____**DOB** _____ **Date** _____

Client Intake

Are you pregnant? Y N Are you nursing? Y N Are you planning on becoming pregnant? Y N

Are you currently taking ACCUTANE or have you taken this in the last 6 months? Y N

Past Personal Medical History (please circle all that apply)

Anemia	Arthritis	Artificial Joint Breast	Bronchitis	Cancer
Bleeding Disorder	Blood Clots	Cancer	Burns	Connective Tissue
Chronic Cough	Cold Sores Depression	Colitis	Diabetes	Disorder
Dialysis	Irregular Heartbeat	Fibromyalgia	Heart Disease	Heart Valve
Heart Murmur	High Blood Pressure	Pacemaker	Defibrillator Migraines	Herpes Simplex
Hepatitis B or	Seizure Disorder	HIV/AIDS	Tuberculosis	Multiple Sclerosis
Phlebitis	Valley Fever	Stroke	Raynaud's Disease	Thyroid Disorder
Ulcers		Metal Implants	Autoimmune Disease	Vitiligo

Past Personal Skin History (please circle all that apply)

Undiagnosed Skin Lesions	Actinic Keratosis	Basal Cell Skin Cancer	Connective Tissue Disorder
Serious Skin Infection	Shingles	Eczema	Squamous Cell Skin Cancer
Melanoma	Lupus Psoriasis	Keloid Scars	Pigment Disorder

Have you ever seen a dermatologist or plastic surgeon for your skin? Y N

If yes, explain: _____

Family History (please circle all that apply)

Adopted	Heart Disease	Stroke	Cancer	Skin Disease	Autoimmune Disorder
Diabetes	Melanoma			High Blood Pressure	

Review of Systems: (please circle) Do you currently have any of the following symptoms:

Poor General Heath	Circulation Problems	Intolerance	Headache	Chest Pain
Swollen Lymph Nodes	Non-Healing Sores	Rashes	Suspicious Moles	Itching
Swollen Legs/Feet	Easy Bruising	Fainting	Bleeding Tendencies	Flushing
		Numbness	Swelling	(Heat/Cold)

Prescription/OTC Medications **Medication Allergy and Reaction**

_____

_____

Have you or anyone in your family ever had unusual reactions to topical anesthetics (numbing cream)? Y N

Latex Allergy Y N Iodine Allergy Y N

Topical Medications: ☐ Retin A ☐ Renova ☐ Tazora ☐ Refissa ☐ Differen ☐ Other:_____

Previous Surgeries? _____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client's Signature _____**Date**_____ **Provider Signature**_____**Date:** _____

Client Name _____Date of Birth _____

Client Intake

DAMN NEAR PERFECT LASER AND SKIN SPA: APPOINTMENT POLICY & SPA CHECK- IN

A 24-hour notice is REQUIRED for any rescheduling or cancellation of your appointments. If you fail to provide us with a 24-hour notice, a $25.00 fee will be added to your account. By signing below you acknowledge and agree to these terms. Please arrive on time to your appointment to receive numbing cream when necessary and/or to complete any skincare analysis forms, and to relax and enjoy a complimentary beverage. For your comfort, we ask that you shower before any body service.

BEFORE & AFTER PHOTO CONSENT

I am authorizing Damn Near Perfect Laser and Skin Spa and its providers and staff members to take before & after pictures of the procedure(s) that will be performed on me. I understand that these pictures will only be used to determine the optimum outcome of my service and/or treatment. They will not be displayed for any reason.

SPA ETIQUETTE

To provide our guests the best experience, we ask that you please silence your cellphones. To maintain a quiet and relaxing environment.

FINANCIAL AGREEMENT

Payment is due in full at the time of service. Acceptable methods of payment are cash, debit and/or credit card.
I understand that my insurance policy is a contract between myself and my insurance company; Damn Near Perfect Laser and Skin Spa is not involved in billing to your insurance company. If I have questions or concerns regarding my coverage for office visits, procedures, lab work, medications, or conditions, I am responsible for obtaining this information. I agree to pay in full for all services if I choose to have the service provided.

HIPAA

Damn Near Perfect Laser and Skin Spa upholds the standard of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum information to only those in need of your health care information, treatment, payment or health care operations, in order to provide health care that is in your best interest.
- You may refuse to consent to the use or disclosure of your personal health information, but *this must be in writing* Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health
- Information (PHI). This information is critical in making appropriate medical decisions.
- If you have any questions regarding this consent, please speak with one of the staff of Damn Near Perfect Laser and Skin Spa

TREATMENT CONSENT AND AUTHORIZATION

I consent to medical screening and medical examination to determine my current health status, other medical evaluations, diagnostic procedures, routine care, and medical treatments which the medical and professional staff of Damn Near Perfect Laser and Skin Spa may deem necessary, advisable, or appropriate. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

My signature here indicates compliance with the above policies and consent.

Client's Signature: _____ Date: _____

Client Intake

Arbitration Form

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contact were unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by state law, and not by a lawsuit or court process, except as therein constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of the arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by provider including any spouse or heirs of the patient and any children whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expectant child. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the provider and its partners, associates, corporation, and the employees, agents, and estates of any of them, must be arbitrated including without limitation claims for loss of consortium, wrongful death, emotional distress, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of judicial officers from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties' consent to the intervention and joiner in this arbitration of any person or entity which would otherwise be a proper additional party in a court action and upon such interaction and any existing court action against such additional person or entity shall be stayed. The parties agree that provisions of state law applicable to health care providers shall apply to disputes with this arbitration agreement. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication. Discovery shall be conducted pursuant to applicable state law; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by applicable laws relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the provider. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If a patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency surgery) patient should initial below:

Effective as of the date of the first medical services _____ **Client's Initials**

If any of the provisions of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have a right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: By signing this contract you are agreeing to have any issue of Medical Malpractice decided by a neutral Arbitration and you are giving up your right to a Jury or Court Trial per Article 1 of this Contract.

Print Client's Name _____ **Date** _____

Client's Signature _____

Provider Signature _____ *Title* ___*Owner*_____

Client Intake

Notice of Privacy Practices

This notice outlines how your medical information may be used and disclosed, as well as how you can access this information.

Our Commitment to Protecting Your Medical Information

We understand that your medical information is personal, and we are committed to safeguarding it. This notice applies to all records of your care generated and maintained by Damn Near Perfect Laser and Skin Spa.

We are legally required to:

1. **Ensure that your identifiable medical information is kept private.**
2. **Provide you with this notice of our legal duties and privacy practices regarding your medical information.**
3. **Follow the terms of the notice currently in effect.**

How We May Use and Disclose Your Medical Information

We may disclose your medical information in the following ways:

- **For Treatment: To doctors, nurses, and other personnel involved in your care, including individuals outside of our clinic such as family members, specialists, or service providers related to your care.**
- **For Operations: To evaluate staff performance, improve programs, and enhance the services we offer to ensure all patients receive quality care.**
- **Appointment Reminders: To remind you of upcoming appointments.**
- **Treatment Options and Services: To inform you of potential treatment options, alternatives, and health-related benefits or services that may interest you.**
- **In Emergencies: To other healthcare providers if you require emergency treatment.**
- **As Required by Law: To comply with federal, state, or local laws.**
- **Public Health and Safety: To prevent a serious threat to your health, safety, or the health and safety of others, as required by public health organizations or federal entities.**
- **Special Situations: For workers' compensation claims, military commands, the Department of Veterans Affairs, court orders, or other legal matters.**

For any uses or disclosures of your medical information not covered by this notice or required by law, we will obtain your written authorization. You may revoke this permission at any time by providing written notice.

Your Rights Regarding Your Medical Information

You have the right to:

- **Access Your Records: You may review and receive a copy of your medical records, which includes both medical and billing information. Requests must be submitted in writing, and we may charge a fee for providing copies.**
- **Request Amendments: If you believe your medical records are incorrect or incomplete, you may submit a written request for an amendment. You must provide a reason supporting your request. We may deny the request if the information:**
    1. **Was not created by us.**
    2. **Is not part of the records we maintain.**
    3. **Is not information you are allowed to inspect or copy.**
    4. **Is accurate and complete.**
- **Accounting of Disclosures: You may request a list of disclosures we have made of your medical information, except for routine disclosures (such as for treatment or payment) or disclosures to you. This request must be in writing and can only cover up to six years prior to the request.**
- **Request Restrictions: You may request restrictions on how your information is used or disclosed. This request must be in writing and specify what information you wish to limit, whether the restriction is for use or disclosure, and to whom the restriction applies. We may deny this request if it conflicts with providing quality healthcare or in an emergency.**
- **Confidential Communication: You may request that we communicate with you in a certain way or at a specific location, such as at work or by mail. Requests must be submitted in writing, and we will accommodate reasonable requests.**
- **Receive a Copy of This Notice: You may request a paper copy of this notice at any time.**
- **File a Complaint: If you believe your privacy rights have been violated, you can submit a written complaint. We will investigate all complaints, and no penalties will be imposed for filing one.**