Eternity Med Spa
LASER HAIR & SKIN CARE

Name: _____ *Date of Birth:* _____
Address: _____ *City:* _____ *Zip:* _____
Cell Phone: _____ *Email:* _____
Would you like to receive text messages/emails for appointment reminders and special offers? _____
Who can we thank for referring you? _____

Please check the appropriate box:

*Are you pregnant? ☐ Yes ☐ No

*Do you have a pacemaker? ☐ Yes ☐ No

*Do you have metal surgical implants? ☐ Yes ☐ No

*Have you been diagnosed with an auto immune disease? ☐ Yes ☐ No

*Are you taking Accutane or any Photosensitive medications? ☐ Yes ☐ No

*On chemo/radiation therapy? ☐ Yes ☐ No

*Do you have a history of seizures? ☐ Yes ☐ No

*Do you have a history of cold sores or herpes virus? ☐ Yes ☐ No

*Are you a diabetic? ☐ Yes ☐ No

*Do you take aspirin? ☐ Yes ☐ No

*Do you have history of Vitiligo? ☐ Yes ☐ No

*Do you have a hormone condition? ☐ Yes ☐ No

*Are you allergic to xylocaine, neozocaine, lidocaine, or tetracaine? ☐ Yes ☐ No

***Are you allergic to latex?** ☐ Yes ☐ No

***Are you allergic to neomycin or polymyxin?** ☐ Yes ☐ No

***Do you have a history of keloid scarring?** ☐ Yes ☐ No

Please list the medications you take: _____
Please list allergies to medications: _____
Do you use sunscreen daily? _____ *Do you easily burn in sun?* _____ *Natural hair color?* _____
Check your natural skin tone:
_____ *fair (doesn't tan)* _____ *light (burns easy)* _____*light/medium (burn then tans)*
_____*medium/olive* _____*medium/dark* _____*dark*

Check any and all areas of concern, we might be able to help!

____ *Over weight/ Hard to loose weight*
____ *Low energy*
____ *Loss of volume in face (cheek bones)*
____ *Sagging eye lids*
____ *Loose skin (face, arms, abdomen)*
____ *Lines/wrinkles around the mouth*
____ *Brown spots, uneven skin tone*
____ *Acne prone skin*
____ *Acne scarring (pits or red scaring)*
____ *Improving skin texture*
____ *Laser hair removal*
____ *Do you want longer eye lashes?*
____ *Other (please explain)*
_____

Would you like a free consultation before/after your treatment today with our Esthetician regarding your skin, after care for your skin, or products? ☐ ***Yes*** ☐ ***No***

I have answered all the questions to the best of my knowledge. I agree that if a photo is taken, it will only be used as a reference in my chart. I also agree that it may be used as a training and reference guide for Eternity Med Spa.

Client Signature: _____ *Date:* _____
Physician Signature: _____

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PATIENT HIPAA CONSENT FORM

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 law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may btain a reviced copy by contacting our office.

By signing this form, you consent to our use and disclosures of protected health information about you for treatment, payment and healthcare operations. You have right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or healthcare operations. The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice. The practice reserves the right to change the Notice of Privacy Policies. The patient may revoke this consent in writing at any time and all future disclosures will then cease.

_____ _____

Patient Signature Date

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Financial Policy

YOUR RESPONSIBILITY
You are financially responsible for all services we provide for you.

METHODS OF PAYMENT
We accept cash, all major credit cards and Care Credit. I am sorry, but we do not accept checks.

MISSED APPOINTMENTS AND NO SHOWS
We see patients on an appointment basis and we request that you call in advance so we can reserve time for you. We make every effort to honor all time commitments and request that you extend the same courtesy to us by letting us know 24 hours in advance if you are unable to keep your appointment. Although we do our best to ensure a courtesy reminder call is given to remind you of your upcoming appointment, we are not responsible for a missed appointment if one was not given. **Patient agrees to pay a fee of $25 or (for appointments scheduled for 30 minutes or longer) forfeit one session of your laser treatment package every time proper notice is not given.**

MINOR PATIENTS
For all services rendered to minor patients, the adult accompanying the patient is responsible for payment. Even if the parents are divorced the parent that accompanies the minor to the appointment is responsible for payment, regardless of the terms of the custodial agreement.

INFORMATION CHANGE
Please advise us of any address or phone number changes promptly.

COLLECTION PROCEDURES
Members of our billing department are always available to help you with questions and or payment options. Once made in writing, agreements are binding. We consider payment by the patient for services rendered to be an important part of the patient's role in the patient/physician relationship. Failure to comply or respond to repeated communications from our office may result in discharge from the practice and/or involvement of an outside collection agency. All prior balances must be resolved before being seen by our physician or in our practice again.

I have read and understand the financial policy, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-tie by the practice. I hereby voluntarily consent to healthcare encompassing recommendations and treatment by my physicians, his/her associates, assistants or other healthcare providers, as may be necessary in my physician's judgment. I have relied on my physician for information in this regard and acknowledge that no warranty or guarantee has been made as to result or care. This form has been fully explained to me, and I certify that I understand its contents.

_____ _____
Signature of Patient or Guardian if a minor Date

_____
Please print patient name