FOUNTAIN OF YOUTH MEDICAL SPA

NEW PATIENT INFORMATION

NAME:_____ D.O.B:_____/_____/_____ AGE:_____

ADDRESS:_____ SEX: M / F

CITY:_____ STATE:_____ ZIP CODE:_____

HOME:_____CELL:_____ WORK:_____

EMAIL ADDRESS:_____

WOULD YOU LIKE TO BE CONTACTED REGARDING CURRENT SPECIALS? YES: (CELL EMAIL BOTH) NO

EMPLOYER:_____ OCCUPATION:_____

EMERGENCY CONTACT:_____ RELATION:_____

HOME:_____CELL:_____ WORK:_____

HOW DID YOU HEAR ABOUT US?

☐ GOOGLE ☐ WEBSITE ☐ FACEBOOK ☐ RADIO AD ☐ TV AD
☐ PHONE BOOK ☐ WORD OF MOUTH ☐ FLYER ☐ GIFT CARD ☐ NEWSPAPER
☐ PHYSICIAN REFERRAL:_____ ☐ STAFF
☐ CURRENT CUSTOMER:_____

DO YOU WEAR GLASSES? Y N DO YOU WEAR CONTACTS? Y N, IF YES, ARE THEY HARD OR SOFT?

LIST ALL MEDICAL ALLERGIES: _____

_____

MEDICATION: (CHECK ALL THAT YOU ARE CURRENTLY TAKING OR HAVE TAKEN WITHIN THE PAST YEAR)

☐ ANTIVIRAL MEDICATIONS ☐ RETINOIDS ☐ ACCUTANE ☐ STERIODS
☐ ASPIRIN/BLOOD THINNERS ☐ ANTIBIOTICS ☐ BIRTH CONTROL ☐ HORMONE REPLACEMENT
☐ ANTI-DEPRESSANTS ☐ HYDROQUINONE ☐ CHLOROQUIN/HYDROXYCHLOROQUIN
☐ IMMUNOSUPPRESSANTS

LIST ALL MEDICATIONS AND/OR HERBAL SUPPLEMENTS THAT YOU ARE CURRENTLY TAKING OR HAVE TAKEN IN THE PAST YEAR:_____

_____

MEDICAL HISTORY:

☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ VASCULAR DISEASE ☐ MELANOMA
☐ EPILEPSY ☐ THYROID HORMONE DEFICIENCY ☐ COLD CORES/HERPES SIMPLEX VIRUS
☐ CANCER ☐ POLYCYSTIC OVARIAN SYNDROME ☐ RADIATION/CHEMOTHERAPY ☐ SEIZURES
☐ METAL IMPLANTS ☐ HEART PROBLEMS ☐ PREGNANT/NURSING ☐ AUTOIMMUNE
☐ VITILIGO ☐ HEPATITIS ☐ STROKE
☐ OTHER:_____

MY CONSULTATION GOALS

1) Please list the top 3 problems on your "Hit List" that you would like to see improvement. (you may list fewer)

FACE	BODY
1) _____	1) _____
2) _____	2) _____
3) _____	3) _____

2) Please list the next 3 concerns (if applicable) you would want to address during your consultation:

1) _____

2) _____

3) _____

3) What adjective(s) best describe your face or body now?

For example: FACE: *rested, youthful, fresh OR tired, angry, sad, droopy, wrinkly*
BODY: *tight, firm, balanced OR droopy, saggy, loose, disproportionate*

FACE: _____

BODY: _____

4) How many years younger / fresher would you like to look? (Please circle that which applies)

0-5 years 6-10 years 11-15 years >15 years

5) How much money do you want to spend to achieve your goals? (Please circle that which applies)

0 - $1,000 $2,000 - $5,000 $6,000 - $9,000 $10,000 or more

6) How much time off can you devote to your enhancement? (Please circle that which applies)

0-1 weeks 1-3 weeks > 3 weeks

7) GOALS: What is it you need to see when you look in the mirror in order to be happy after your procedure?

_____

_____

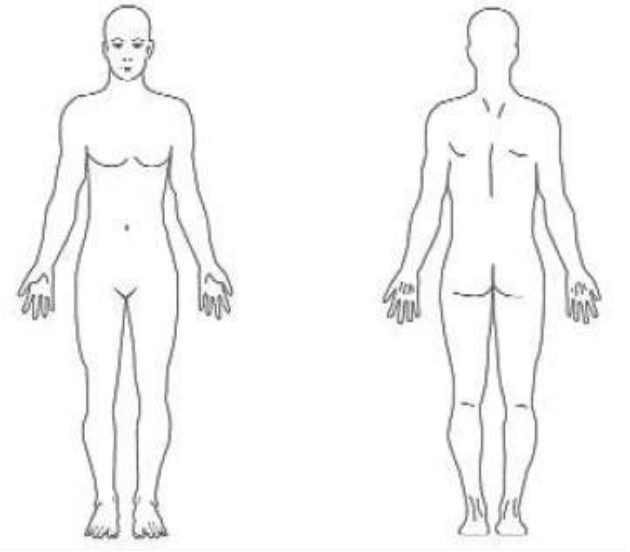
8) How much downtime and/or time off work can you devote to your recovery after your procedure?

_____

11) What are your concerns? (Please check those that apply)

☐ LINES AND WRINKLES	☐ MELASMA	☐ DULL, LIFELESS SKIN
☐ UNDER EYE CIRCLES/WRINKLES	☐ SAGGING SKIN	☐ ACNE/ ROSACEA
☐ LOSS OF VOLUME/TIRED LOOKING	☐ PORES	☐ BROKEN CAPILLARIES
☐ VEINS ON FACE AND /OR LEGS	☐ SCARRING	☐ TROUBLE SLEEPING
☐ SUN DAMAGE/ BROWN SPOTS	☐ THIN LIPS	☐ CELLULITE
☐ TIRED OF SHAVING/RAZOR BUMPS	☐ WEIGHT ISSUES	☐ FATIGUE
☐ HOT FLASHES/MOOD SWINGS	☐ NUTRITIONAL CONCERNS	☐ DIGESTIVE ISSUES
☐ TIRED OF PUTTING ON MAKE-UP	☐ BELLY FAT (POUCHES)	

☐ OTHER:_____



9) What procedures have you had? (Please circle those that apply)

Botox	Filler (Restylane/Juvederm ect)	IPL/Laser Fotofacial
Laser Hair Removal	Cellulite Treatments	Thermage/ Laser Tightening
Fraxel/Laser Resurfacing	Other: _____	

10) What procedures would you be interested in having? (Please circle those that apply)

Botox	Filler (Restylane/Juvederm ect)	IPL/Laser Fotofacial
Laser Hair Removal	Cellulite Treatments	Thermage/ Laser Tightening
Fraxel/Laser Resurfacing	Other: _____	

PLEASE READ CAREFULLY AND INITIAL AND SIGN AFTER READING

PAYMENT POLICY:

ALL APPOINTMENTS MUST BE PAID IN FULL AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND CARE CREDIT. THERE WILL BE A CHARGE OF $50 FOR ANY RETURNED CHECKS. THE FOUNTAIN OF YOUTH DOES NOT EXTEND CREDIT OR OFFER PAYMENT PLANS IN HOUSE.

INITIALS _____

APPOINTMENT AND CANCELLATION POLICY:

THE FOUNTAIN OF YOUTH MEDICAL SPA HAS A 24 HOUR CANCELLATION / RESCHEDULING POLICY. IF YOU MISS YOUR APPOINTMENT, CANCEL OR CHANGE YOUR APPOINTMENT WITH LESS THAN 24 HOURS NOTICE, YOU WILL BE CHARGED $50. THIS POLICY IS IN PLACE OUT OF RESPECT FOR OUR CLIENTS AND STAFF. CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE ARE DIFFICULT TO FILL. BY GIVING LAST MINUTE NOTICE OR NO NOTICE AT ALL, YOU PREVENT SOMEONE ELSE FROM BEING ABLE TO SCHEDULE INTO THAT TIME SLOT.

INITIALS_____

RECORDS:

WE KEEP CONFIDENTIAL RECORDS AT THE FOUNTAIN OF YOUTH MEDICAL SPA. INFORMATION IS NOT DISCLOSED UNLESS YOU DIRECT US TO DO SO OR UNLESS THE LAW AUTHROIZES SUCH. MEDICAL RECORDS ARE AVAILABLE UPON REQUEST FOR A FEE OF $20. PLEASE ALLOW 10 BUSINESS DAYS TO PROCESS YOUR MEDICAL RECORDS REQUEST.

INITALS _____

INSURANCE:

THE FOUNTATIN OF YOUTH MEDICAL SPA DOES NOT BILL INSURANCE COMPANIES, YOU MAY SUBMIT A COPY OF RECIEPT FOR REIMBURSEMENT AS PER YOUR INSURANCE POLICY.

INITIALS_____

BY SIGNING BELOW I UNDERSTAND EACH OF THE STATEMENTS THAT I HAVE INITIALED AND I HAVE HAD ANY QUESTIONS REGARDING THE STATEMENTS ANSWERED BY THE STAFF OF THE FOUNTAIN OF YOUTH.

_____ _____

CLIENT SIGNATURE DATE

FOUNTAIN OF YOUTH MEDICAL SPA
NOTICE OF PRIVACY POLICY

UNDERSTANDING YOUR HEALTH INFORMATION:

A RECORD OF YOUR VISIT IS MADE EACH TIME YOU COME TO OUR FACILITY. THIS RECORD MAY CONTAIN PERSONAL, IDENTIFYING INFORMATION ABOUT YOU, YOUR HEALTH AND TREATMENTS HERE AT THE FOUNTAIN OF YOUTH MEDICAL SPA. THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSES:

- TO PLAN YOUR CARE AND TREATMENT
- LEGAL DOCUMENTATION DESCRIBING THE CARE YOU RECEIVE
- TO HELP TECHNICIANS/PHYSICIANS MAKE DECISIONS ABOUT YOUR CARE

YOUR HEALTH INFORMATION RIGHTS:

YOUR RECORDS ARE CONFIDENTIAL AND YOU HAVE THE RIGHT TO:

- REQUEST THAT WE LIMIT CERTAIN USES AND RELEASES OF YOUR INFORMATION
- REQUEST THAT YOU GET A COPY AND ARE ALLOWED TO SEE YOUR RECORDS
- REQUEST THAT ANY AND ALL COMMUNICATIONS OF YOUR HEALTH INFORMATION BE MADE BY DIFFERENT MEANS OR TO A DIFFERENT LOCATION.

OUR RESPONSIBILITIES:

WE ARE REQUIRED TO:

PROTECT THE PRIVACY OF YOUR INFORMATION
RESPECT REASONABLE REQUESTS TO COMMUNICATE HEALTH INFORMATION BY DIFFERENT MEANS OR TO DIFFERENT LOCATIONS

ACKNOWLEDGMENT OF RECEIPT:

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE FOUNTAIN OF YOUTH MEDICAL SPA'S "NOTICY OF PRIVACY POLICY".

_____ _____

CLIENT SIGNATURE DATE

I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION THE PERSON(S)

_____
_____
_____
_____

_____ _____

CLIENT SIGNATURE DATE