RejuvenationMD®
Aesthetic Skin Treatment & Wellness Center

NEW PATIENT INFORMATION & MEDICAL HISTORY (PAGE 1 OF 2)

PATIENT DEMOGRAPHICS (CAPITAL LETTERS PREFERRED)

Name: _____ Birthday: _____ /_____ /_____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Preferred Telephone Contact: ☐ Cell Phone ☐ Home Phone

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: ( ) _____ - _____ Relationship: _____

How were you referred to us? _____

COSMETIC CONCERNS

What concerns do you have that brought you in today?

☐ **Acne**	☐ **Hair Loss**	☐ **Rosacea**	☐ **Urinary Incontinence**
☐ **Cellulite**	☐ **Hyperpigmentation**	☐ **Sagging Skin**	☐ **Unwanted Hair**
☐ **Double Chin**	☐ **Melasma**	☐ **Scars**	☐ **Vaginal Aging/Dryness**
☐ **Excess Fat**	☐ **Nail Fungus**	☐ **Sexual Wellness**	☐ **Veins**
☐ **Excess Sweat**	☐ **Pores**	☐ **Under Eye Bags**	

How long has (have) this (these) bothered you? _____

What have you tried in the past? _____

Have you had a consultation regarding these concerns? ☐ Yes ☐ No

If so, what prevented you from moving forward? _____

Is there a specific timeframe you are working with and why? _____

Do you have a budget that you would like to stay within? _____

Are there specific procedures you are interested in? (Check all that apply)

☐ **Coolsculpting**	☐ **BBL Forever Young**	☐ **Moxi**	☐ **Hair Restoration**
☐ **Cool Tone**	☐ **Diva**	☐ **Hair Removal**	☐ **Halo Skin Resurfacing**
☐ **Chemical Peels**	☐ **Scarlet**	☐ **Priapus Shot**	☐ **Vampire Breast Lift**
☐ **O-Shot**	☐ **Facials**	☐ **Kybella**	☐ **Vampire Facial/Facelift**
☐ **Botox**	☐ **Fillers**	☐ **Sculptra**	☐ **PDO Threads**
☐ **Vein treatments**	☐ **Sofwave**	☐ **Agnes**	☐ **Microneedling**

☐ **Other:** _____

COSMETIC HISTORY

Have you ever had or received any of the following noninvasive aesthetic procedures? (Check all that apply)

☐ **Botox**	☐ **Fillers**	☐ **IPL/Photofacials**	☐ **Facials**
☐ **Hair Removal**	☐ **Body Contouring**	☐ **Laser Resurfacing**	☐ **Skin Tightening**

☐ **Other:** _____

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NEW PATIENT INFORMATION & MEDICAL HISTORY PAGE (2 OF 2)

Do tan regularly (naturally or artificially including salons, spray tans or tanning creams)? ☐ Yes ☐ No

Do you have any permanent makeup/tattoos on your face? ☐ Yes ☐ No. If yes, where? _____

Have you had any of the following aesthetic procedures? (Check all that apply)

☐ **Facelift** ☐ **Neck Lift** ☐ **Breast Surgery** ☐ **Eyelid Surgery**

☐ **Other:** _____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No If yes, who? _____

Are you currently under the care of a dermatologist? ☐ Yes ☐ No If yes, who? _____

Do you have any known ALLERGIES: ☐ Yes ☐ No If yes, please list:

_____

Name and city for your pharmacy: _____

Do you smoke? ☐ Yes ☐ No If yes, check all that apply: ☐ Tobacco ☐ Marijuana ☐ Vape

Do you drink alcohol? ☐ Yes ☐ No

Do you have any of the following medical conditions? (Check all that apply)

☐ **Cancer** ☐ **Diabetes** ☐ **Metal Implants (incl IUDs)** ☐ **High blood pressure**

☐ **Cold Sores** ☐ **Genital Herpes** ☐ **Migraines** ☐ **Seizure Disorder**

☐ **Hepatitis** ☐ **Hormone Imbalance** ☐ **Sexual Dysfunction** ☐ **Urinary Incontinence**

☐ **Seizure Disorder** ☐ **Clotting Issues** ☐ **Autoimmune Disease** ☐ **HIV/AIDS**

Please list any other health conditions: _____

For females: Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

MEDICATIONS

Please list any **oral** medications that you are taking: _____

Please are you taking any of the following medications? (Check all that apply)

☐ Birth Control ☐ Hormones ☐ Aspirin/NSAIDS (Ibuprofen, Naprosyn)

☐ Blood Thinners (such as Coumadin, Warfarin, Plavix, Xarelto, Aggrenox, Pletal)

Have you ever used Accutane? ☐ Yes ☐ No If yes, when did you last use it? _____

Are you using any of the following **topical** medications or creams? (Check all that apply)

☐ Retin-A© ☐ Hydroquinone or bleaching agents Others (Please list): _____

ACKNOWLEDGEMENT

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 doctor, esthetician, or staff of my current medical conditions/medications and to update this history. I understand that any products or procedures not utilized within 12 months of purchase date will be forfeited. I also have been made aware that there are no refunds for deposits, payments or treatments received, 2 days' notice is required for cancellations, or a fee may be incurred, and children & pets are not recommended and/or allowed to be in the office.

Signature: _____ **Date:** _____

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SKIN MATRIX

Name: _____Date: _____

Please answer the following questions by circling the number which best describes you.

My ethnic origin is closest to:	Very fair (Celtic and Scandinavian)	0
	Fair-skinned Caucasian with light hair and light eyes	1
	Pale-skinned Caucasian with dark hair and dark eyes	2
	Olive-skinned (Mediterranean, some Asian, some Hispanic)	3
	Dark-skinned (Middle Eastern, Hispanic, Asians, some African)	4
	Very dark-skinned (African)	5
My eye color is:	Light blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light brown	2
	Dark brown	3
	Black	4
The color of my skin that is not normally exposed to sun is:	Pink to reddish	0
	Very Pale	1
	Pale with a beige tan	2
	Light brown	3
	Medium to dark brown	4
	Dark brown - black	5
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when burn resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is so dark I can't tell	6

Total:

If your score is:	Your skin type is:
0 – 3	**1**
4 – 7	**2**
8 – 11	**3**
12 – 15	**4**
16 – 19	**5**
20 – 24	**6**

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REJUVENATIONMD POLICIES AND AUTHORIZATIONS

Refund Policy

We are sorry, but due to the nature of our services and products, there are no refunds and all sales, including deposits, are final. In lieu of a refund, store credit for unused services or an unopened product may be authorized. If you believe your situation warrants further consideration, please contact us to request a copy of our refund request policy. In no event will a refund be made for services received.

Forfeiture Policy

In order to maximize the potential for optimal patient outcomes, patients need to complete their treatments in a timely manner. Subsequently, treatments, deposits, or credit not utilized within 12 months of purchase date will be forfeited.

Cancellation Policy

We require a minimum of 2 business days' notice for all cancelled or rescheduled appointments. Patients who fail to cancel their appointment, or who cancel/reschedule within 2 business days of their appointment, will be charged a $100 non-refundable fee. Repeated violations of this policy will result in forfeiture of the deposit to schedule or any pre-purchased treatment(s) for which the missed, cancelled, or rescheduled appointment was scheduled, and dismissal from the practice.

Credit Card on File Agreement

All patients are required to maintain a credit card on file which will be kept securely with our payment provider. This credit card will be used to pay for non-refundable new patient appointment deposits, fees consistent with our Cancellation Policy, unpaid balances, and may only be used for regular transactions and payments in limited, non-routine circumstances. By signing this agreement, you authorize RejuvenationMD to keep your signature and credit card information securely on-file in your account. Further, you authorize RejuvenationMD to charge your credit card for any non-refundable appointment deposits, fees incurred from violation of the Cancellation Policy, unpaid balances, and for your treatment(s) and/or retail purchase(s) in limited, non-routine circumstances.

ACKNOWLEDGMENT/AUTHORIZATION:

Patient Name (Please print): _____ Date_____

Patient Signature: _____

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HIPAA INFORMATION AND CONSENT FORM

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. 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, text, 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 several 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. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.
8. 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.
I certify that I am a competent adult of at least 18 years of age and that I am not currently on any mood altering or antidepressant medications that may affect my understanding of this paperwork. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

ACKNOWLEDGMENT:

Patient Name (Please print): _____ Date: _____

Patient Signature : _____

RejuvenationMD®
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EMAIL COMMUNICATION CONSENT FORM

Risks of using email

For the ease of our patients, our office would like to offer the opportunity to communicate by email. Transmitting patient information poses several risks and the patient should not agree to communicate with RejuvenationMD, PLLC (RMD) via email without understanding and accepting these risks.

The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Email senders can misaddress, resulting in it being sent to many unintended recipients.
- Employers/online services may have a legal right to inspect and keep emails that pass through their system.
- Even after deletion of the email, back-up copies may exist on a computer.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email.
- Emails can introduce viruses, generally damage, or disrupt the computer.
- Email can be used as evidence in court.

Conditions of using email

Our office will use reasonable means to protect the security and confidentiality of email information sent and received, however, we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, communication, and appointment reminders.

Consent to use email includes agreement with the following conditions:

- Emails to or from the patient concerning treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, authorized individuals will have access the medical record/email (e.g. billing staff).
- Our office will send you appointment reminders by email.
- Our office may forward emails internally to those involved, as necessary, for healthcare operations and other handling. RMD will not forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although our office will endeavor to read and respond promptly to all emails from the patient, it is not guaranteed that any email will be read and responded to within any period of time. The patient should not use email for medical emergencies or other time sensitive matters.
- If the patient's email invites a response from RMD and a response is not received within a reasonable time period, it is the patient's responsibility to follow up.
- Please detail any information that you would not like to be communicated over email (this can be modified at any time by notifying RMD in writing):

  _____

- RMD is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.

Instructions for communication by email

To communicate by email, the patient shall:

- Inform RMD of any changes in the email address body.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
- Should the patient require immediate assistance or have serious or worsening condition, the patient should not rely on email. Instead, the patient should call RMD, their primary care provider or proceed to the ER.

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand both pages of this consent form and had my questions answered. I understand the risks associated with the communication of email between the office and me, and consent to the conditions outlined herein, as well as any other instructions that the office may impose to communicate with patients by email. I acknowledge that I may revoke this consent at any time by written request. I acknowledge RejuvenationMD, PLLC has the right to, upon the provision of written notice, withdraw the option of communicating with me through email. By signing the below, I also acknowledge that I have the choice to revive communications via other more secure means such as by telephone. By signing below, I agree to hold RejuvenationMD, PLLC harmless for unauthorized use, disclosure or access of your protected health information sent to the email address I provide.

Patient Name (Please print): _____ Date: _____

Patient Signature: _____

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Marketing Authorization Form

About RejuvenationMD's Marketing Authorization Form

RejuvenationMD, PLLC (RMD) must ask for your permission to send to you via email, text message or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e. office promotions that include Botox events and/or special discounts). Our office DOES NOT sell our patients' names or other personal information**.**

Authorization

By signing this authorization, I hereby authorize (RMD) and its Business Associates to send me marketing material and information by way of email, mail and text message.

I understand that this authorization is voluntary and that my ability to receive services by and from RMD is not conditioned on the signing of this authorization.

I understand that this authorization is effective until revoked in writing. Further, I understand that I may revoke this authorization at any time, except to the extent that RMD has relied on this authorization, by sending a written statement of revocation that specifically refers to this authorization to (revocation will be effective upon receipt):

RejuvenationMD, PLLC

Attn: Marketing

325 E. George Hopper Rd. Suite, 101

Burlington, WA 98233

ACKNOWLEDGMENT/AUTHORIZATION:

Patient Name (Please print): _____ Date: _____

Patient Signature: _____

RejuvenationMD®
Aesthetic Skin Treatment & Wellness Center

YOUR PERSONALIZED TREATMENT PROGRAM

AESTHETICS:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

BODY CONTOURING:

_____ _____

_____ _____

_____ _____

PRODUCTS:

_____ _____

_____ _____

TOTAL _____

ACKNOWLEDGEMENT OF ESTIMATE: I understand and agree that the prices for the items listed above are valid for 30 days from the date listed below. Additionally, I am aware that should I agree to purchase any of the services or products offered by RejuvenationMD, a deposit or payment in full may be required at the time of scheduling, or prior to the treatment being performed. I am aware of RMD's policies and procedures, including those regarding late cancellations (within 2 business days) and refunds (there are no refunds for payments/deposits received). Price quote is not valid unless signed and dated.

Patient Name (Please print): _____ **Date:** _____

Patient Signature: _____