RejuvenationMD®
Aesthetic Skin Treatment & Wellness Center

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

PATIENT DEMOGRAPHICS

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**		

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**	☐ **Kybella**	☐ **Skin Tyte**	☐ **Z-Wave**
☐ **Instalift**	☐ **Diva**	☐ **Diva Tyte**	☐ **Halo Skin Resurfacing**
☐ **Chemical Peels**	☐ **LED**	☐ **Priapus Shot**	☐ **Vampire Breast Lift**
☐ **O-Shot**	☐ **Facials**	☐ **BBL Forever Young**	☐ **Vampire Facial**
☐ **Botox**	☐ **Fillers**	☐ **HydraFacial**	☐ **Oxygen Facial**
☐ **Vampire Facelift**	☐ **Microcurrent**	☐ **Microdermabrasion**	☐ **Microneedling**
☐ **Dermaplaning**			

☐ **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: tanning salons, spray tans or tanning creams)? ☐ Yes ☐ No

Do you have any permanent makeup or 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? _____

List any known ALLERGIES to medications, herbal supplements or over the counter products:

_____

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** ☐ **Hyperpigmentation** ☐ **High blood pressure**

☐ **Herpes/Cold Sores** ☐ **HIV/Aids** ☐ **Migraines** ☐ **Seizure Disorder**

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

☐ **Seizure Disorder** ☐ **Blood Clotting Abnormalities** ☐ **Autoimmune Disease**

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 or health conditions 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

Appointment Reminders & Authorizations

Appointment Reminder Policy: It is the policy of RejuvenationMD (RMD) to send appointment reminders by text message, email, and/or phone to your preferred telephone contact. If you wish to opt out of receiving text message reminders you can text the word STOP in your reply. Standard text messaging rates may apply.

Refund and Cancellation Policy

We are sorry, but due to the nature of our services and products, all sales, including deposits, are final. In addition, any procedures, deposits, or credit not utilized within 12 months of purchase date will be forfeited. We require a minimum of 2 business days' notice for all cancelled or rescheduled appointments. Patients who fail to cancel their appointment, or who make a late cancellation/reschedule within 2 business days of their appointment, may be subject to one or more of the following:

- Forfeiture of the deposit to schedule or pre-purchased treatment(s) for which the missed, cancelled, or rescheduled appointment was scheduled.
- $100 or $250 fee and/or non-refundable deposit to schedule for future appointments

Holiday, Prolonged Visit and Children Accompaniment Policies

During the weeks of New Years, Memorial Day, 4th of July, Labor Day, Thanksgiving and Christmas, a $250 deposit to schedule is required for all appointments. This can be applied to the service provided that day. In the event your appointment is for a pre-paid service, a deposit to schedule will not be required; however, failure to abide by the Cancellation Policy will result in forfeiture of the treatment(s) scheduled for that day and/or current loyalty points. Should you request same day treatment that requires us to reserve longer than 1 hour of time, you may be asked to place a non-refundable deposit that can be used towards your treatment that day. Should you fail to show for this appointment or cancel within 2 business days' (see Cancellation Policy above) and want to reschedule, another deposit may be necessary to secure your follow up visit.

Minors are always welcome for treatment when accompanied by a parent or with a prior signed consent form. Childcare services are not provided on site and out of respect for all our guests, we ask that children do not accompany you to a scheduled appointment.

Credit Card on File Agreement

It is the policy of RMD to ask for a credit card upon check in which may be used later to pay for any unpaid balances, non-refundable appointment deposits or fees consistent with our Refund and Cancellation Policy or for regular transactions and payments. At check in, your credit card information will be obtained and kept securely. Further by signing below, you authorize RMD to keep your signature and credit card information securely on-file in your account. You authorize RMD to charge your credit card for any unpaid balances, non-refundable appointment deposits or fees and for any approved treatment or retail purchase.

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 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. 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 unencrypted 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 unencrypted email without understanding and accepting these risks.

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

- The privacy and security of unencrypted email communication cannot be guaranteed and unencrypted emails containing your medical care or PHI could be intercepted and read by a third party.
- 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 has 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 consent to unencrypted email communication and agreement

By signing the below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks and consent to the conditions outlined herein, as well as any other instructions that the office may impose to communicate with patients by email.

By signing the below, you acknowledge that messages containing clinically relevant information may be incorporated into the medical records at the provider's discretions.

By signing you also acknowledge that you have read and fully understand this consent form and had your questions answered. You acknowledge that you may revoke this consent at any time by written request. You acknowledge RejuvenationMD, PLLC has the right to, upon the provision of written notice, withdraw the option of communicating with you through email. By signing the below, you also acknowledge that you have the choice to revive communications via other more secure means such as by telephone. By signing below, you agree to hold RejuvenationMD, PLLC harmless for unauthorized use, disclosure or access of your protected health information sent to the email address you 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: _____

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COVID-19 RISK INFORMED CONSENT

I understand that I am opting for an elective treatment/procedure that is not urgent and may not be medically necessary. I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result federal and state health agency recommend social distancing. I recognize that RejuvenationMD, PLLC (RMD) is closely monitoring this situation and has put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure, and I give my express permission for RejuvenationMD and all staff to proceed with the same.

I understand that, even if I have been tested for COVID-19 and received a negative test result, the test in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before, during, and/or after my appointment may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death In addition, after my elective appointment, I may need additional care that may require me to go to an emergency room or hospital.

I understand that COVID-19 may cause additional risks, some of many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the appointment itself.

I have been given the option to defer my appointment to a later date. However, I understand all potential risks, including but not limited to potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired appointment and/or procedure.

I release RejuvenationMD PLLC, medical doctors and staff, from all liability should I or anyone with whom I come in contact with test positive for COVID-19. 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: _____