Welcome to

Los Feliz MedSpa

Our goal is to respond to all of our patients' needs and to provide the highest quality care. In order to provide the information and services you desire for the health and appearance of your skin, we invite you to complete the following questionnaire.

PATIENT INFORMATION

Date: Name: Birthdate: / /

Address:

City: State: Zip:

CONTACT INFORMATION

Cell: ☐

Other: ☐

*If phone is your preferred method of contact, please indicate which number you would like to use for appointment confirmations.

E-Mail:

*Emails are not sold to outside vendors, all information is kept confidential. Email is used for appointment reminders, newsletters, specials, and other communication between LFM and the client.

DO YOU PREFER TO HAVE YOUR APPOINTMENTS CONFIRMED VIA ☐ **EMAIL** **OR** ☐ **PHONE** ☐ **TEXT**

EMERGENCY CONTACT INFORMATION

Emergency Name:

Emergency Number:

EMPLOYMENT INFORMATION

Employer: Occupation:

HOW DID YOU HEAR ABOUT US? (Check all that apply)

Friend /Family (Please Specify)

Internet Site ☐ Google ☐ Yahoo ☐ ☐ Yelp

Other Not Listed ☐ Please Specify -

Walk – In ☐

ISSUES OF INTEREST TO YOU: (Check all that apply)

☐ Skin Rejuvenation
☐ Reduction of sun damage
☐ Treatment of Rosacea (Redness of Skin)
☐ Wrinkle Reduction
☐ Increased Facial Volume
☐ Permanent Hair Removal
☐ Reduction of age spots
☐ Evening out skin tone (blotchiness)
☐ Body Contouring
☐ Other, please specify _____

_____

_____

_____

PREVIOUS COSMETIC TREATMENTS (Check all that apply)

☐ Acid Peel	☐ Botox/Dysport/Xeomin	☐ CoolSculpting	☐ Intense Pulse Light
☐ Fillers	☐ Laser Procedures	☐ Mesotherapy	☐ Microdermabrasion

FITZPATRICK SKIN TEST

- ☐ **Type 1** - Always burns, never tans. Red or Blonde hair, light eyes.
- ☐ **Type 2** - Somewhat tans, mostly burns
- ☐ **Type 3** - Sometimes burns, mostly tans, aka "olive"complexion.
- ☐ **Type 4** - Rarely burns, almost always tans, aka "olive" complexion
- ☐ **Type 5** - Moderately pigmented, (Indian, Hispanic…)
- ☐ **Type 6 -** African American

WHAT IS YOUR SKIN TYPE?

☐ Oily ☐ Normal ☐ Dry ☐ Sensitive ☐ Combo

WHAT IS YOUR NATURAL HAIR COLOR?

☐ Blonde ☐ Brunette ☐ Black ☐ Red

WHAT IS YOUR EYE COLOR?

☐ Blue ☐ Green ☐ Brown ☐ Hazel ☐ Gray ☐ Amber

MAJOR ALLERGIES

☐ Milk	☐ Papaya	☐ Lidocaine
☐ Sugar/Beets	☐ Prilocaine	☐ Latex
☐ Sulfur	☐ Aspirin	☐ Citric Fruits
☐ Benzoyl Peroxide		

List allergies to drugs, make-up, food, and skin:

List all medications you are currently taking:

Have you ever been diagnosed with:

☐ Diabetes	☐ Psoriasis	☐ Asthma
☐ Keloids	☐ Eczema	☐ Allergies

Are you currently under a physician's care?
☐ Yes Specify_____

Have you done or ever had/have any of the following?

☐ Herpes Simplex	☐ Chemotherapy/Radiation
☐ Tumors/Growths	☐ Smoke
☐ Asthma	☐ Fainting/Dizzy spells
☐ Skin cancer	☐ Hyperpigmentation
☐ Circulatory issues	☐ Seizures

☐ Vitaligo, Lupus or any other autoimmune disease.

Check all that apply:

☐ Been on Accutane in the past 6 months		
☐ Laser resurfacing in the past year		
☐ Tan your skin (sun, tanning beds, creams)	How long ago?:	_____
☐ Recently undergone a skin peel	How long ago?:	_____
☐ Been on or currently using Retin-A	Last Application:	_____
☐ Currently pregnant	How far along?:	_____
☐ Taking birth control pills		
☐ Tested for HIV	☐ Positive	☐ Negative
☐ Immune disorder that would impair healing process		
☐ Prone to genital herpes		
☐ Prone to cold sores		
☐ Have a venereal disease	What are they?	_____
☐ Taking oral or injectable steroids	What condition?	_____
☐ Have or had sclerotherapy	How long ago?	_____

When a scar appears on your skin, is it significantly dark in color? _____

Going back three generations, what is your family ancestry? _____

CANCELLATION POLICY:

We require cancellations to be made with at least a 24 hour notice before the time of your scheduled appointment. We realize emergencies occur; however, we must cover our expenses.

There will be a **charge of $75 for cancellations of less than 24 hours notice for every 30 minutes** of appointment time booked, if you have a series, the service from this series will be deducted whichever is the lesser of the two. By scheduling an appointment, you are agreeing to our cancellation policy. Cancellations for Monday appointments are required to be cancelled by Saturday at 2 PM. We thank you for your understanding.

LATE POLICY:

Your appointment time is reserved exclusively for you! If your arrival time is 15 minutes or later than your scheduled appointment, this may result in a shortened appointment. We reserve the right to reschedule your service.

NO-SHOW POLICY:

There will be a charge of $75 for cancellations of less than 24 hours notice for every 30 minutes of appointment time booked, if you have a series, the service from this series will be deducted whichever is the lesser of the two. If you have a gift card, the amount would be deducted from the gift card.

PAYMENTS/REFUNDS:

Payment for all procedures at the Los Feliz MedSpa is due at the time of visit and is **non-refundable**. All sales are final; however The Los Feliz MedSpa does have an exchange policy that gives you options in case the need arises. Should you wish to discontinue your treatment in the midst of a series you will receive credit for the pro rata share of unused treatments. The treatments that have already been provided will be charged at current single treatment price to calculate the remaining credit. This credit may be used to purchase other treatments, not products, offered by the Los Feliz MedSpa.

PRICES: Prices are subject to change without notice.

With this signature I understand and agree to the terms of the above Policy. I certify that all information provided is true and accurate. I agree to hold harmless Los Feliz MedSpa and its agents for any adverse reactions due to omitted information and/or misinformation on the Health Questionnaire and/or from actions, which deviate from pre and post care procedures.

Client Signature: _____ Date: _____

We realize you have choices so we thank you for your business!

CREDIT CARD INFORMATION TO BE KEPT ON FILE FOR CANCELLATION/NO SHOW CHARGE

☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover

Card Number: _____ CVS #: _____

Expiration Date: _____

HIPAA/Privacy Statement- THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 14, 2003* and will remain in effect until It Is amended or replaced by us. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Hanan Botras. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION: We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health Information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health Information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved In the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health Information to notify, or assist In the notification of a family member or anyone responsible for your care, In case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are Incapacitated we will use our professional Judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health Information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or it you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances, if the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health Information to provide you with appointment reminders, Including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to Inspect and get copies of your health Information (and that of an Individual for whom you are a legal guardian,) There will be some limited exceptions. If you wish to examine your health Information; you will need to complete and submit an appropriate request form, Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, If requested, will be $ .75 for each page end the staff time charged will be $ 25.00 per hour Including the time required to locate and copy your health Information. If you want the copies mailed to you, postage will also, be charged, if you prefer a summary or an explanation of your health information, we will provide It for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it Is Inaccurate or Incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Notice of HIPAA/Privacy Statement Received

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which indicates how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice listed on the page above. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Print your name here. Date

Signature

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to emergency situation it was not possible to obtain an acknowledgement

☐ We weren't able to communicate with the patient

☐ Other (please provide specific details)

Employee Signature: Date:

PRICING SHEET

Date: _____ **Prices Good Until: _____**

Client Name: _____

Procedure of Interest		# of Sessions	Total Price	Discount Applied	Final Price (Including Discount)
	Single				
	Package				
	Single				
	Package				
	Single				
	Package				
	Single				
	Package				
	Single				
	Package				

To receive discounted or package price, payment must be made in full at beginning of first visit. If you prefer making monthly payments, we offer CARE CREDIT. Please inquire at the front desk for more details.

Comments/Special Instructions: