PATIENT INTAKE FORM

FULLNAME | DATE OF BIRTH

ADDRESS | CITY | STATE | ZIP

MOBILE PHONE □ ok to leave message HOME PHONE □ ok to leave message WORK PHONE □ ok to leave message

EMAIL ADDRESS

HOW WOULD YOU LIKE TO BE NOTIFIED?
circle all that apply
telephone | email | text

EMERGENCY CONTACT NAME AND PHONE NUMBER

OCCUPATION

HOW DID YOU HEAR ABOUT US? if referred by a client, please list their name

WHAT IS THE NATURE OF YOUR VISIT?

MEDICAL CONDITIONS (please check all that apply, and describe if necessary)

□history of facial or cold sore or genital herpes
□ use of blood thinner, aspirins, or NSAIDS
□HIV or exposure to a person with HIV
□ hepatitis or known exposure to hepatitis A, B, or C
□ Acutane use in the past 6 months
□ connective tissue disorder or autoimmune disease
□ use of Retin-A, Retinol, Hydraquinone, or skin thinners
□ epilepsy or seizures
□ history of stroke
□problem scarring
other:
□ Current Medical Diagnoses:

PLEASE LIST ANY MEDICATIONS, VITAMINS, OR HERBAL SUPPLEMENTS YOU ARE TAKING.

PLEASE LIST ANY ALLERGIES YOU HAVE.

ARE YOU PREGNANT OR BREASTFEEDING? □ yes □ no

HEIGHT AND WEIGHT MALE/FEMALE

HAVE YOU EVER HAD SURGERY? if yes, please describe

WHAT SKINCARE OR LASER TREATMENTS HAVE YOU HAD IN THE PAST?

24 HOUR CANCELLATION POLICY and MISSED APPOINTMENT (NO-SHOW) POLICY

Should I cancel or miss an appointment (excludes Coolsculpting) with less than 24 hours notice, I may be charged a missed appointment fee of $100, unless a deposit for the service has been made, in which case I will be charged the amount or the deposit. Coolsculpting appointments cancelled less than 48 hours before appointment will result in forfeiture of $500 deposit. Returned checks will result in a $50 dollar returned check fee. A credit card will be used to secure appointments and will be charged for any missed appointment and/or cancellation fees. No-show fee for missed appointments will be $100.

PAYMENT POLICY

Payment is due in full upon completion of service. We do not participate with medical insurance. Patient is responsible for payment of all medical and aesthetic services.

I have answered all questions on this form truthfully and disclosed my medical history to the best of my knowledge. I also give my permission to receive texts and/or e-mails discussing my medical care when appropriate.

PATIENT SIGNATURE: | DATE

7811 Montrose Rd. Suite 310
Potomac, MD 20854
(301) 417-8372

Medical Information Release Form
(HIPPA Release Form)

Name:__________________________________ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____

[ ] Child(ren)____

[ ] Parent(s)____

[ ] Primary care_______________________________________

[ ] Other____

[ ] Information is not to be released to anyone

This ***Release of information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number___________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call (no details)

[ ] do not leave any messages

The best time to reach me is (*day*)_________________ between (*time*)____________

Signed: _______________________________________ Date: ____/____/_______

Witness: ______________________________________ Date: ____/_____/_______

Protecting the confidentially of the information you and your healthcare providers share with us is important to Potomac Medical Aesthetics. this notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures of Health Information

We use health information about you for treatment, payment and administrative purposes. We may use or disclose identifiable health information about you without your authorization for several other reasons that are lawful within the regulations of HIPAA. Subject to several requirements, we may give out health information without your authorization for public health purposes, for auditing purposes and for emergencies. We provide information when required by law, such as for law enforcement in specific circumstances.

For any reason and all other circumstances, we will ask for your written authorization before using or disclosing identifiable health information about you.

If you choose to sign an authorization to disclose information, you can later revoke the authorization to stop any further uses of discloser.

We may change our policies at any time to comply with federal law. Before we make significant change, however, we will post a notice of change in the waiting area of each medical dispensary.. You can also request a copy of ur policy at any time. For more information about our privacy practices, contact the medical director at the number below.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the medical director at the number below.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. The name and address of the person you can contact for further information conceding our privacy practice is:

Potomac Medical Aesthetics
7811 Montrose Rd. Suite 310
Potomac, MD 20854
301.417.8372

Acknowledgement of Statement

I have received/read a copy of Potomac Medical Aesthetics notice of Privacy Practices

Date: ____

Print Name: ____

Signature: ____