A New You, LLC

515.444.5754 • Anewyoudbq.com

PATIENT INFORMATION AND INTAKE FORM

Date: _____

Name: _____
First Middle Last

DOB: _____ Age: _____

Street Address: _____

City: _____ State:_____ Zip:_____

Home telephone: _____

Cell number: _____OK to communicate via email/text? Y/N

Email: _____

Occupation: _____

How did you hear about us?: _____

Ethnic Background (must be as accurate as it can):
_____

Marital Status (please circle): Married Single Divorced Widow Living with Significant other

EMERGENCY CONTACT INFORMATION
In case of emergency please contact: _____
Relationship to you: _____
Contact number: _____

CURRENT MEDICAL HISTORY
Please state the reason(s) for your visit and describe any symptoms you are experiencing:
_____
_____

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Hospitalizations/Surgeries (including tonsils, gallbladder, appendix, cosmetic):

Procedure	Year

Medications/Supplements

Medication/Supplement	Reason for taking	Date began	Dose

Have you had any allergic reaction to the following?

Local anesthetics (ex: Lidocaine)	Y	N	
Penicillin or other antibiotics	Y	N	If yes, please explain _____
Sulfa drugs	Y	N	
Latex	Y	N	
Sedatives	Y	N	
Iodine	Y	N	
Aspirin	Y	N	
Drugs	Y	N	If yes, please explain _____
Food	Y	N	If yes, please explain _____
Other	Y	N	If yes, please explain _____

If yes, what happens? _____

Please list any relevant family history: _____

_____

_____

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List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Steroids: Y N P **If yes, for what condition and dosage?** _____
Smoking: Y N P **If yes, how much per day?** _____
****Smoking in any amount compromises the healing process and may negatively affect the outcome of your treatment**.
Analgesics: Y N P **Caffeine:** Y N P **Ounces per day if Yes**: _____
Alcohol: Y N P **If yes, how much per week**? _____
Recreational Drugs: Y N P

Have you ever had or are you currently experiencing any of the following?

Acne	Y	N	Lupus/ SLE	Y	N
Anorexia	Y	N	Lymph Disorder	Y	N
Anemia	Y	N	Migraines	Y	N
Asthma	Y	N	Multiple Sclerosis	Y	N
Bleeding Tendency	Y	N	Pacemaker/Electrical implant	Y	N
Blood Disorder	Y	N	Poor Wound Healing	Y	N
Bruising Tendency	Y	N	Respiratory Disease	Y	N
Cancer- Active	Y	N	Rheumatoid Arthritis	Y	N
Cancer- Remission	Y	N	Raynauds	Y	N
Cardiac Disorder	Y	N	Scleroderma	Y	N
Cold Sores	Y	N	Shingles	Y	N
Current Cold/Flu	Y	N	Sjogrens	Y	N
Diabetes	Y	N	Skin Rash currently	Y	N
Epilepsy/ Seizures	Y	N	Staph Infection/ MRSA	Y	N
Hepatitis Type _____	Y	N	Stroke	Y	N
High Blood Pressure	Y	N	Thyroid Disorder	Y	N
High Cholesterol	Y	N	Please list any other Conditions:		
HIV	Y	N	_____		
Infection Currently	Y	N			
Kidney Disease	Y	N	_____		
Leukopenia	Y	N			
Liver Disease	Y	N	_____		
Low Blood Pressure	Y	N			

If you answered YES, to any of the above questions, please state how this medical condition is being managed. Name of Physician, Name of Medications, other Treatments, etc.

_____

_____

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I attest that the above information is accurate to my knowledge and will alert A New You, LLC if any information about my health changes.

Client Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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SKIN TYPING WORKSHEET

Patient Name: _____ Date: _____

Skin Score		0	1	2	3	4
	What is your eye color?	Light Blue or Grey	Blue or Green	Hazel or Light Brown	Dark Brown	Brownish Black
	What is your natural hair color?	Red, Sandy Red	Blonde	Dark Blonde, Chestnut, Brown	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful, redness, blistering, and peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burn	Never burn
	To what degree do you turn brown?	Hardly or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never has problems in the sun
	When did you last expose yourself to the sun, tanning beds or self0tanning creams?	More than 3 months ago	2-3 months	1-2 months	Less than 1 month ago	Less than 2 weeks ago
	How often is the area that you want to have treated exposed to the sun?	Never	Hardly Ever	Sometimes	Often	Always
TOTAL	**Score** / **Skin Type** 0-7 I 8-16 II 17-25 III 26-30 IV Over 30 V - VI					

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TREATMENT SCREENING

Name: _____ Date: _____

If you answer yes to any of these questions you may not be able to participate in certain laser treatments at this time.

Are you pregnant? Yes No

Do you or have you had skin cancer? Yes No

If so, where did you have skin cancer? Area(s) _____ _____

Is it in the area you are wanting to treat with Fractional? Yes No

When was your last dermatologist check? Date: _____ _____

Do you experience Keloid scarring or any other textual skin changes after procedures? Yes No

Are you currently on any topical or oral antibiotic acne medication? Yes No

If so, what are you using? Medication(s):_____ _____

When was your last dose? Date(s):_____ _____

Have you recently been on Accutane? Yes No

What is your ethnic background (i.e. Italian, French, Hispanic, African American, etc.)?

_____ _____

The following are precautionary when participating in certain laser treatments.

Do you use exfoliating products? (i.e. Retin-A, Retinol, or Aggressive Scrubs) Yes No

If so, when were they last used? _____

Do you have a cold, the flu, or any other sickness? Yes No

Do you take cortico steroids? Yes No

Do you have blood disorders? Yes No

Do you use blood anticoagulants? Yes No

Do you have Herpes in or around the treatment area? Yes No

If so, you must take an antiviral for 2 days prior to treatment, day of treatment, and 2 days post treatment.

Do you have Diabetes or any other medical condition that will impair the healing process? Yes No

Do you experience Vitiligo? Yes No

Do you have Eczema or Psoriasis? Yes No

Do you experience Allergic Dermatitis? Yes No

Is your immune system compromised in any way? (i.e. HIV, Steroids or age) Yes No

Do you have any collagen diseases such as Ehlers-Danlos or Scleroderma?	Yes	No
Do you have any social engagements in the next 2 days?	Yes	No
Do you currently have any dermal fillers in the treatment area?	Yes	No

CLIENT RIGHTS AND RESPONSIBILITIES

We are committed to serving you with compassion, care, and respect. As one of our valued clients you are entitled to the following:

You have the right:

- To be treated with respect and dignity.
- To know the names and professional status of the person(s) serving you.
- To privacy and confidentiality.
- To receive accurate information about your health-related concerns.
- To know the effectiveness and potential side-effects of all forms of treatment.
- To participate in choosing the form of treatment best suited to your skin.
- To receive education and counseling about treatments.
- To review your medical record with your clinician.
- To amend your records.
- To receive any information about potential services or related services.

You have the responsibility:

- To seek medical attention promptly, and to provide useful feedback.
- To be honest about your medical history.
- To be honest about your sun exposure.
- To ask questions about anything you do not understand.
- To follow health advice and instructions.
- To report any significant changes in your health.
- To respect clinic policies.
- To show up to appointments or cancel 48 hours in advance.

I authorize A New You, LLC to perform the treatment or procedures recommended. I acknowledge no guarantee; either expressed or implied has been made to me regarding the outcome of any treatment or process.

I fully understand that it is impossible for anyone to make a guarantee regarding the outcome of any medical treatments or procedures.

I understand I am financially responsible for all procedures due when services are rendered, and for any appointment I fail to attend without 48 hours' notice.

I authorize the release of information to a licensed physician of the facility's choosing for the purpose of professional interpretation and establishment of their recommendations.

Client Signature: _____ Date: _____

Reviewed by: _____ Date: _____

CANCELLATION POLICY

SPA APPOINTMENTS

We request that you give us ample notice if you need to cancel or reschedule your appointment. Ideally 24 – 48 hours prior.

We do require a credit card to be kept on file for spa appointments, and if you no show your scheduled appointment your card will be charged a $50 No Show Fee.

I agree and understand A New You, LLC's cancellation policy.

Print Name: _____

Client Signature: _____ Date: _____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how A New You, LLC may use and disclose your protected health/personal information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected information. "Protected health/personal information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health/ Personal Information
Your protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you to support business operations of this office, if requested by you to a finance company to pay for your care and any other use required by law.

Treatment: We will use and disclose your protected health/personal information to provide, coordinate, or manage your health care, and any other related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health /personal information, as necessary, if, as a result of our services, you require treatment by a physician. Your protected health/personal information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and or you.

Payment: Your protected health/personal information will be used, if requested, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health/personal information in the following situations without your authorization. These situations include: as required by law; public health issues, communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors and organ donation; research; criminal activity and national security; workers' compensation; inmates; required uses and disclosures. Under the law, we must make disclosure to you and, when required by the Secretary of the U.S. Department

of Health and Human Services, to investigate or determine our compliance with the requirements of the Standards for Privacy of Individually Identifiable Health Information set forth at 45 C.F.R. parts 160 and 164.

Other Permitted and Required Uses and Disclosures will be made only with your written authorization or opportunity to object unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights
Following is a statement of your rights with respect to your protected health/personal information.

You have the right to inspect and copy your protected health/personal information. Under federal law, however you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected health/personal information.

You have the right to require a restriction of your protected health/personal information. This means you may ask us not to use or disclose any part of your protected health/personal information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health/personal information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. We

We are not required to agree to a restriction that you may request. If our medical director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your protected health/personal information will not be restricted. You then have the right to use another service provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us; upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to amend your protected health/personal information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare for rebuttal to our statement and will provide you a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health/personal information.

We reserve the right to change the terms of this notice and make the new notice provisions effective to all protected health information we maintain. We will inform you by mail of any changes. You then have the rights to object or withdraw as provided in this notice.

3. Complaints

You may complain to us or to the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPPA Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Signature of Client: _____ Date: _____

Signature of Staff: _____ Date: _____

CONSENT FOR PULSED LIGHT/LASER TREATMENTS

I give my consent and authorization to A New You, LLC to treat me with cosmetic laser and/or pulsed light modalities. This includes, but is not limited to, IPL photo facials, fractional laser skin resurfacing, skin tightening, laser and intense pulse light hair removal.

I understand that these procedures are purely elective, that the results may vary with each individual, no guarantee can be provided in regards to the outcome of medical procedures such as these, and multiple treatments may be necessary to achieve maximum results.

I acknowledge and understand that:

- Serious complications are rare, but possible.
- Common side effects include temporary redness and mild “sunburn” like effects that may last anywhere from a few hours to 3-4 days.
- Pigment changes, including hypo-pigmentation (lightening of skin) or hyper-pigmentation (darkening of skin) lasting 1-6 months or longer, may occur.
- Freckles may temporarily or permanently disappear in treated areas.
- Other potential risks include crusting, itching, pain, bruising, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result.
- Laser and intense pulse light treatments can cause eye injury and protective eyewear must be worn during the all treatments.
- I understand that sun or tanning lamp exposure and not adhering to the post-care instructions provided by A New You, LLC may increase my chances of complications.

I consent to photographs being taken for use in the follow areas: evaluation of treatment effectiveness, medical education and training, marketing, media stories, advertising and other sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

I acknowledge that pre- and post-treatment instructions have been discussed with me. The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatments.

Client Signature:_____Date: _____

Print Name: _____ Date: _____

Witness Signature: _____ Date: _____

Print Name: _____ Date: _____

PRE AND POST CARE FOR LASER HAIR REDUCTION AND PHOTOFACIALS

PRE:

- Avoid the sun for 4-6 weeks before and after the treatment. Always apply a broad-spectrum sunscreen of at least 30 SPF (We recommend 8-9% zinc oxide). Re-apply every 2-3 hours as needed. Remember that clothing and hats do not give complete protection from UV Radiation.
- Avoid electrolysis, plucking, and/or waxing for 6 weeks prior to treatment
- If you have a history of herpes, prophylactic antiviral therapy must be started the day before treatment and continued one week after treatment.
- The use of tanning creams, tanning beds, or bronzers must be discontinued before and during treatments.

POST:

- Immediately after treatment there may be erythema (redness) and edema (swelling) at the treatment site. This usually lasts 2 hours or longer. The erythema may last up to 10 days. The treatment area may feel like a sunburn for a few hours after the treatment, but it will subside.
- Apply ice as needed.
- Hydrocortisone may be used for 3 – 5 days post treatment.
- No heat, such as saunas, steam rooms, Jacuzzis, extremely hot showers, or strenuous activities. No prolonged heat for a minimum of 48 hours post treatment.
- Avoid sun exposure to avoid hypo-pigmentation and hyper-pigmentation.
- Avoid picking or scratching the treated areas. Please do not use any hair removal products or similar treatments (i.e. electrolysis, plucking, and/or waxing). Those will disturb the hair follicle. Shaving is permitted.
- Up to 2 weeks post treatment you will notice shedding of the treated hair. This is not new growth. You can clean and remove the hair by washing or wiping the area with a wet cloth.
- Treat your skin gently for at least 24 hours after your treatment.
- Always apply a broad-spectrum sunscreen of at least 30 SPF (we recommend 8-9% zinc oxide) and protect the treated area from sunlight for a month. Sun exposure may cause hyperpigmentation. Re-apply every 2-3 hours as needed. Remember that clothing and hats do not give complete protection from UV Radiation.
- **Hair removal only – Up to 2 weeks post treatment you will notice shedding of the treated hair. This is not new growth.

I have read and understand the pre and post treatment instructions.

Client Signature: _____ Date: _____

Print Name: _____ Date: _____

Provider Signature: _____ Date: _____

Print Name: _____Date: _____