Today's Date: _____ Who should we thank for referring you? _____

Full Name_____DOB:_____

Mailing Address: _____

City: _____ State: _____ Zip _____

Primary Phone: _____ Is this a cell? **Y/N**

Can we send automated messages/appointment reminders to this number? **Y/N**

Email: _____

Emergency Contact Name and Phone: _____

Pharmacy Name/ Phone: _____

Currently pregnant **Y/N** If yes # of weeks? _____ Nursing **Y/N**

Allergies (Medication/Topical product/fragrances/shellfish/latex): _____

_____

Current daily prescription/OTC medications:

_____

_____

_____

Are you currently using: □ Aspirin □ NSAIDS (Motrin, Advil, Aleve) □ Plavix (clopidogrel) □ Coumadin (warfarin) □ Pradaxa □ Eliquis □ Lovenox (heparin) Have you ever used Accutane (isotretinoin)? **Y/N** If yes, how long ago? _____

Do you have any of these medical conditions? □ NONE □ Diabetes □ High blood pressure □ Herpes/cold sores □ Arthritis □ Seizure Disorder □ Hepatitis □ Hormone Imbalance □ PCOS □ Any Active Infections □ Thyroid Imbalance □ Blood clotting/bleeding abnormalities □ Cancer Type?:

_____

Chronic Medical Conditions not listed above: _____

_____

_____

Procedures / products of interest to you: __ Xeomin/Dysport/Botox __ Dermal Fillers __Hydrafacial __ Chemical Peels __ Medical Grade Facials __ Micro-needling __ Laser Hair Removal __ Skin Care Products __ Laser Resurfacing/IPL __ Age Spot treatment __ Acne treatment (face or back) __ Rosacea / Facial Veins Other, please specify: _____

Have you had any medical spa treatments in the past (i.e. chemical peel, laser treatment, micro needling, hydrafacial, botox, fillers, etc?: _____

Where?: _____ When was your last treatment?:_____

If you answered yes above, have you ever had any adverse effects from those treatments?: **Y/N**

Reaction? _____

Have you ever had any facial surgery performed? **Y/N** TYPE: _____

Are you currently seeing a dermatologist? **Y/N** If YES, for what condition and which doctor:

_____

Do any of the following pertain to you?: Form thick/raised scars (keloids) from cuts or burns? **Y/N**

Have circulation problems **Y/N** Areas of persistent redness? **Y/N** rosacea **Y/N** eczema **Y/N**

Have hyperpigmentation (darkening of the skin)/hypopigmentation (lightening of the skin)? **Y/N**

Are you on medications that make you sensitive to light/sun? **Y/N** acne **Y/N**

blackheads/whiteheads **Y/N** psoriasis **Y/N** milia **Y/N** age spots **Y/N** vein abnormalities **Y/N**

Are you using preparations containing sulfur, resorcinol, or salicylic acid? **Y/N**

What skin care regimen are you currently using? (brand if known):

□ Toner: _____ □ Cleanser_____

□ Moisturizer _____□ Eye cream _____

□ exfoliant_____□ serum _____

□ Sunscreen: _____

Skin type: □ Oily/congested □ Dry/dehydrated □ Sensitive/Red □ Acne prone □ Normal

Ethnicity (if willing to answer)_____

Fitzpatrick Skin Type: (circle one):

I (Always burns, never tans)

II (Always burns, sometimes tans)

III (Sometimes burns, always tans)

IV (Rarely burns, always tans) **V** (Brown, mod pigmented Skin)

VI (Black skin)

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 aesthetician, therapist, nurse, or doctor of my current medical or health conditions and to update this history.

Patient Name (Print) : _____

Patient Signature : _____ Date: _____

Policies, Procedures, Agreements and Consents

The next two pages are intended to provide you with detailed information about our policies, programs, agreements and consents. Please read each section thoroughly, make sure any concerns are addressed and that any questions you have are answered before making your final decision to move forward with the treatment process.

HIPPA Patient Consent

Our office is committed to protecting the privacy of your medical information. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and updated in 2013) is a federal law that governs the use and disclosure of a person's health information. Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. The Notice contains a "Patient Rights" section describing your rights under the law. The following statements cover the basics of your rights as a patient under HIPAA: Our office has a "Notice of Privacy Practices" and you have the right to review a detailed copy of our Notice before signing this HIPAA Patient Consent. This "Notice of Privacy Practices" is available in our offices. Protected health information may be disclosed for treatment, payment, or health care operations. We reserve the right to change the terms of our "Notice of Privacy Practices" at any time. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to restrict the uses of your protected health information. You may revoke this HIPAA Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Additionally, it is the policy of this office to remind patients of their appointments. We may do this via live telephone calls, automated appointment reminder calls, text messages, e-mails, U.S mail, social media or by any means convenient to the practice. We may also send you other communications informing you of changes to office policy, new technology and specials that you might find valuable or informative. That said, contact will only come directly from us; we will never sell or trade your private information including phone numbers, e-mail address or mailing addresses. You may opt out of any or all communication measures any time by contacting us in writing.

By signing the next page of this document, you certify that you have read our HIPAA Patient Consent and have had the opportunity to review a more detailed version if so desired. Your signature also signifies that you agree with the above statements and this policy. GLOW MEDSPA provides this form and information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (updated in 2013).

Telemedicine consent and Video/Photo Agreement

My signature below certifies that I understand, agree and consent that BelleVi MedSpa and its employees, independent contractors, associates, agents and representatives (collectively and hereby known as, "BelleVi MedSpa",) may take photographs and/or use video (for "store & forward" or teleconferencing technology) of the area to be treated before initial treatment begins & at some or all reoccurring visits (genital area photos and videos are usually NOT taken). These recordings will be available only to our medical staff members to assess the patient and track the progression of each treatment and are part of the medical record. BelleVi MedSpa follows extremely strict HIPPA guidelines regarding patient confidentiality and privacy & therefore names and recordings are used internally and only the treated area/area to be assessed will be shown in these photographs & videos.

Appointment Policy

BelleVi MedSpa strives to treat all clients at their scheduled times. We understand that emergencies arise, but we require appointment cancellations be made at least 24 hours prior to your appointment. If you do not call to cancel or fail to show up for your appointment, we reserve the right to charge a $25.00 no show fee. After 2 late cancellations/no show appointments, we will require pre-payment of the scheduled service at the time of booking.

*As a courtesy to our clients we try to send out email and text reminders. However, not receiving those reminders will not excuse a missed appointment.

Payment Policy

I understand that I am financially responsible and agree to pay all the charges in full today for all services rendered. My signature below certifies that I hereby seek the services of BelleVi MedSpa and its employees, independent contractors, associates, agents and representatives (collectively and hereby known as, “BelleVi MedSpa”,) for esthetic services. I understand that these services are voluntary procedures and are not covered by Medicare, Medicaid, HMO, PPO, or private insurance plans. I understand that BelleVi MedSpa will not submit any claims to any insurance carriers. I understand that payment is due before services are rendered. I also understand and agree that if I pay for a package of services using a credit card, check or finance company and the payment is not honored or is subject to a chargeback at any time for any reason that I am still fully responsible for payment for the treatments I receive and agree to pay for them at the undiscounted (“pay as you go”) rate. I agree to pay a fee of $25.00 for each check or charge that is not honored by my bank. Lastly, I fully acknowledge that I am personally responsible for all fees and charges incurred in connection with my purchase and I completely understand that there is NO refunding of any patient fees, payments, charges, credit, gift certificates, product purchases or pre-paid packages.

Release of Records: I authorize the release (verbal or in writing) of confidential medical information to any person or entity including health care operations which may be liable to me or my practitioner(s) for quality management, utilization review, transfer, and follow-up purposes.

I acknowledge that I have received and read the HIPPA Patient Consent, the Telemedicine/video/photo agreement, the appointment policy and the payment policy

I understand that a copy of this agreement may be used with the same effectiveness as the original.

Patient Name (Print) : _____

Patient Signature : _____ Date: _____

Submit questions or concerns to the COO at 828-330-2103 x803