Skin Questionnaire/Patient History

Last name_____First_____Middle_____
Address _____City _____ State ____ Zip _____
Home ph _____Cell ph _____ Birth date _____ Date of Visit _____
Emergency Contact_____ Email _____ (used for our monthly e-Newsletter filled with Skin Care Tips, information about Upcoming Events and other Spa Specials and Promotions)
How did you hear about Golden Glow? _____
Referral Name_____

Patient History

1. Have you ever taken Accutane? [] YES [] NO When _____Dosage ___Months____
2. Last use of tretinoin? [] YES [] NO
3. Do you use birth control pills or other forms of hormone therapy? [] YES [] NO
4. Are you pregnant or are you attempting pregnancy? [] YES [] NO
5. Do you have history of shingles/cold sores? [] YES [] NO **6.**Are you on [] Valacyclovir [] Zovirax [] Valtrex
7. Are you breastfeeding? [] YES [] NO Any history of Gold therapy in past [] YES [] NO
8. History of skin cancer? [] YES [] NO Type _____ Treatment taken _____
9. Are you taking any blood thinners? [] YES [] NO
10. Facial Implants? [] YES [] NO
11. History of Seizures? [] YES [] NO
12. Waxing Services within 7-14 Days? [] YES [] NO
13. Irregular, Pigmented moles, warts or growths, unidentified facial growth or mark? [] YES [] NO
14. Keloids, pigmented scars, icepick scars, new scar tissue? [] YES [] NO
15. Pacemaker or other metal implants? [] YES [] NO
16. History of Rosacea, telangiectasia/couperose? [] YES [] NO
17. Acne [] YES [] NO Stage_____
18. Last use of skin-lightening or bleaching agents_____ Which agent_____
19. Last exposure to the sun? _____
20. Any thyroid conditions? [] YES [] NO
21. Allergies to any medications/Anesthesia?
22. Any Medical Illness____ Diabetes____ HTN____ Bleeding Problems____ Heart Problems_____
23. Are you taking any regular prescription/unprescribed medications? _____
24. Previous Procedures (please give dates) PEELS LASERS
[] Botox _____ [] Light _____ [] Ablative
[] Fillers_____ [] Medium _____ [] Non-ablative
[] Surgery _____ [] Deep_____
[] Comedome Extraction_____ OTHER TREATMENTS: _____
[] No of facials in last 12 months _____

Areas of your concern

[] Lines/wrinkles [] Skin Elasticity [] skin laxity [] Acne Scars
[] Skin texture [] Uneven color tone [] Skin pigmentation [] Redness on face
[] Skin hydration [] Skin disorder [] Mole changes [] Skin lesion
[] Other concerns

_____

_____

Current Skin Care Product used and Daily Regimen:

_____

Patient Signature_____ Date_____

Take advantage of a *Complimentary* Skin Analysis today.
Follow Up Treatments history

Date	Treatment Type	Any change In Medical history	Any new Medications	Last sun exposure/ Tanning	Any chances of being pregnant	Signature

Golden Glow Medical Spa Cancellation Policy

As of 5/14/13 Golden Glow Medical Spa will be adjusting its cancellation policy. If you are unable to make your appointment please call at least 24 hours before to cancel as a courtesy to other patients and staff. If you do not call to cancel your appointment before 24 hours or are a no call no show on the day of your appointment you will be charged a $50 FEE for Every Appointment Missed. This courtesy enables us to compensate our employees for their time, and maintains a higher availability of our time for you as well as others. By scheduling an appointment, you are agreeing to our cancellation policy. Patients arriving more than 10 minutes late may result in a shortened appointment or a cancellation if there is not enough time to complete the procedure. If your Appointment is cancelled due to late arrival you will be charged the $50 cancellation fee. Thank you for your understanding and compliance.

Golden Glow Medical Spa Management

Print Sign Date

I have read and understand the cancellation policy

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received your **Notice of Privacy Practice** containing a more complete description of the uses and disclosures of my health insurance information. I understand that the office of Dr. Mira Mahajan has the right to change its **Notice of Privacy Practices from time to time.** I may contact this office at any time at the below address to obtain a current copy of the **Notice of Privacy Practice.**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), that I have certain rights to privacy regarding the protection of my health information. I understand that this information can and will be used to:

- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that this office is not required to agree to my requested restrictions, but once agreed upon, this office is bound to abide by such restrictions.

Patient Name (Printed):_____
Signature:_____
Date:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:
Date:_____ Initials:_____ Reason:_____

Golden Glow Medical Spa
150 Clearwater/Largo Rd. N Suite 1,Largo, FL 33770 *(727) 683-0894

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability Accountability Act of 1996("HIPPA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information. As required by "HIPPA", we offer this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposed: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, billing or collection activities, and utilization reviews.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and costumer services. An example would be medical review, legal services and auditing functions.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosers will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to that extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to Dr. Mira Mahajan (Privacy Officer):

- The right to request restrictions on certain uses and disclosers of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1,2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, above violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPPA or to file a complaint.

Golden Glow Medical Spa

Authorization to Release and Disclose photographs

This photographic release pertains to photographs taken during the following treatment:

I, (print name) _____, voluntarily consent to the Copyright, publication, and use of my picture and likeness by Golden Glow Medical Spa, affiliates, successors, and assignees.

By signing this form, I am allowing Golden Glow Medical Spa, affiliates, successors, and assignee to disclose photographs taken of me before, during, and after treatment.

(Please initial either yes or no on each line)

For research, educational information purposes:	Yes___	No___
For publications in a medical journal and /or textbook:	Yes___	No___
For general advertising, publicity, or promotional purposes:	Yes___	No___

I understand that the image may be seen by members of the general public. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

I hereby release Golden Glow Medical spa from any claim, demand, cause, action, or proceeding of whatever nature arising out of publication and distribution of the said photographs in accordance with the terms of this release. This release also includes affiliates, successors, and assignees of Golden Glow Medical Spa. I also understand that I can revoke (or take away my permission to allow Golden Glow Medical Spa to disclose photographs of me at any time by sending a letter to Golden Glow Medical Spa Medical Director telling him or her not to disclose photographs of me to affiliates, successors, or assignees of Golden Glow Medical Spa. If I send a letter saying that I revoke my authorization, Golden Glow Medical Spa's Medical Director will not disclose any more photographs of me after he or she receives the letter. However, the Medical Director will not need to return any photographs disclosed prior to his or her receipt of the letter.

I understand that once my photographs have been disclosed to Golden Glow Medical Spa, affiliates, successors, and assignees the photographs will no longer be protected by federal privacy laws. However, Golden Glow Medical Spa's affiliates, successors, and assignees will not use the photographs except as permitted on this authorization form. I understand that I will be given a signed copy of this form.

I hereby release Golden Glow Medical Spa, its affiliates, successors, and assignees from any claim demand, cause, action, or proceeding of whatever nature arising out of publication and distribution of the said photographs in accordance with the terms of this authorization.

Print Name:_____ Signature:_____ Date: _____

Financial Responsibilities

The following procedures/surgeries: Fractional CO2, Thermitight, Liposuction, and Facial fat transfer, require specific payment criteria in regards to booking and cancellations. The total includes fees charged by your doctor, the cost of the surgical supplies, anesthesia, and operating room reservation for the day of the procedure/surgery. Mahajan Cosmetic Center and Golden Glow Medical Spa **DO NOT** accept any type of insurance, so you will be responsible for full payment of your procedure/surgery. The fees charged for this procedure do **NOT** include any potential future costs for additional procedures that you elect to have or require in order to revise, optimize, or complete your outcome results of your surgery. In signing the consent for this surgery/procedure, you acknowledge that you have been informed about its risk and consequences and accept responsibility for the facility decisions that were made along with the financial costs of all future treatments.

_____I understand that with cosmetic surgery, I am responsible for full surgical fee(s) quoted to me.

_____I understand when scheduling any of the above procedures/surgery a deposit of 50% must be made.

_____I understand that there will be a non-refundable fee for booking and scheduling this procedure/surgery of **10% of total cost** of the procedure/surgery, which is a part of the overall surgical fee.

_____Should you cancel your surgery without an approved medically acceptable reason, submitted in writing and acceptable to the practice, within **1 week** of your scheduled surgery, this fee is forfeited. While this may appear to be charged for service(s) which were not provided, this fee is necessary to reserve time in the OR, doctor's time availability and in the practice, which are done when you schedule.

_____I understand and unconditionally and irrevocably accept the financial responsibilities as outlined above

Patient's Name Signature

Date