Mahajan
Cosmetic Center
Golden Glow Medical Spa

Skin Questionnaire & Patient History

Last Name _____ **First** _____ Middle _____
Address _____ City _____ State ____ Zip _____
Home phone _____ Cell _____ Birth date _____ Todays Date _____
Emergency Contact _____
Email _____
(You will receive a monthly e-Newsletter about Spa Specials and Promotions).
How did you hear about Golden Glow Medical Spa? _____

Patient History

1. Have you ever taken Accutane? [ ] YES [ ] NO If yes, when? _____ Dosage _____ Months _____
2. Any use of tretinoin/retinols/RetinA? [ ] YES [ ] NO If yes, when? _____
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
8. Any history of Gold therapy in past [ ] YES [ ] NO
9. History of skin cancer? [ ] YES [ ] NO If yes, what type _____ Treatment taken _____
10. Are you taking any blood thinners? [ ] YES [ ] NO
11. Facial Implants? [ ] YES [ ] NO
12. History of Seizures? [ ] YES [ ] NO
13. Waxing Services within 7-14 Days? [ ] YES [ ] NO
14. Irregular, Pigmented moles, warts or growths, unidentified facial growth or mark? [ ] YES [ ] NO
15. Any keloids, pigmented scars, icepick scars, new scar tissue? [ ] YES [ ] NO
16. Pacemaker or other metal implants? [ ] YES [ ] NO
17. History of Rosacea, telangiectasia/couperose? [ ] YES [ ] NO
18. Acne [ ] YES [ ] NO
19. Any use of skin-lightening or bleaching agents [ ] YES [ ] NO If yes, what type and when? _____
20. Last exposure to the sun? _____
21. Any thyroid conditions? [ ] YES [ ] NO
22. Allergies to any medications/Anesthesia? _____
23. Any additional allergies (food, environmental)? _____
24. Any Medical Illness? _____
    [ ] Diabetes [ ] HTN [ ] Bleeding Problems [ ] Heart Problems
25. Are you taking any regular prescription medications? _____
    Please explain _____
26. Ethnicity _____
27. Previous Procedures (please give dates)
    [ ] Botox _____ [ ] Fillers _____

Golden Glow Medical Spa

"We Create Beautiful & Healthy Skin For All Ages"

Visit us on **www.goldenglowmedicalspa.com** 150 Clearwater Largo Road, North, Suite 3, Largo, FL, 33770

727-683-0894

Follow us on Instagram @goldenglowmedspa

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[ ] Light Peel _____ [ ] Medium Peel _____
[ ] Deep Peel _____ [ ] Non-ablative Lasers _____
[ ] Ablative Lasers _____ [ ] Surgery_____
[ ] Comedome Extraction_____ [ ] Deep Exfoliation _____
[ ] Additional Treatments_____

Number of facials in last 12 months _____

Areas of your concern:
[ ] Lines and Wrinkles [ ] Skin Elasticity [ ] Skin Laxity [ ] Acne Scars
[ ] Skin Texture [ ] Uneven Color Tone [ ] Skin Pigmentation and Dark Spots [ ] Redness and Broken Capillaries
[ ] Skin Hydration [ ] Skin Disorder [ ] Mole Changes [ ] Skin Lesion
[ ] Other Concerns

_____
_____

Pharmacy:
Address _____
Phone Number _____

Current Skin Care Product used and Daily Regimen:

_____
_____
_____

Patient Signature_____ Date_____

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Financial Policies & Information Collected

Because we provide elective cosmetic procedures, the care provided at Mahajan Cosmetic Center is not covered by any medical insurance programs.

Some of the content and medical spa services available in our location and on our website require registration. We collect contact information (including name, telephone number, mailing address, DOB, and email address, etc.) to contact you regarding appointments, as well as promotions such as monthly specials and special events.

Credit card information may be stored by our merchant processing partner, and charges may incur if you are enrolled in our VIP membership program, no call/no show fees, late cancellation policy, deposits for some procedures, and outstanding balances. This information is kept confidential, and only the last 4 digits of the credit card are kept on file for your security.

Payment Options

We accept cash, gift cards, major credit cards including AMEX, Care Credit and Green Sky Financing. Personal checks are not accepted.

Initials_____

Payment Policy

New Patients: A $25 deposit is required to hold all new patient appointments. The $25 fee will only be charged should you cancel your appointment within the 24 hour window, or no call/no show. This fee may be waived at the discretion of the practice.

Initials_____

Payment for all medical spa services is due at the time of treatment. For specially packaged or grouped treatments, payment for the entire package is due at the time of the first scheduled treatment.

Initials_____

Deposits

For scheduling purposes, the following cosmetic procedures require a 50% deposit due at the time of booking: Deep Laser Resurfacing, Fractional C02, Silhouette InstaLift, ThermiTight, Tumescent Liposuction, & Facial Fat Transfer. If a scheduled procedure is cancelled within 24 hours, (unless written medical emergency) 10% of the deposit shall be forfeited.

Initials_____

Refund Policy

All sales are final. Before a service is performed, please consider all the required protocols and side effects. We are committed to the best patient experience possible, and we are available to answer any questions or concerns that you have in regards to services we offer before purchase. Any value of services or treatments that are pre-paid or "banked" may be used towards other spa services, treatments & products or transferred to another person's account.

Initials_____

Product Sales

Maintaining your skin with quality products is essential. We are happy to exchange product within 14 days of purchase. Although rare, this includes defective packaging, just please let us know within 14 days so we can get your product exchanged.

Initials_____

Cancellations & Refunds

We understand that a situation may arise that could force you to cancel or postpone your treatment. Please understand that such changes not only effect our staff, but other patients as well, so we ask as a courtesy you please allow 24 hours to notify of us of a cancellation. Failure to cancel within the 24 hour window (or Friday before a Monday appointment) will result in a $50 late fee. A pattern of missed, or non-cancelled visits may result in a discharge from the practice.

Initials_____

Revisional Treatment

The practice of medicine, especially cosmetic medicine, is not an exact science, and although best possible outcomes are anticipated, there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results you will get. Occasionally, additional treatments may be required. These could result in additional charges for which you may be responsible.

For all neuromodulator injections (Botox, Xeomin & Dysport) **two week** follow-ups are scheduled and complimentary touch-ups are administered if necessary.

Initials_____

*These financial policies are subject to change with or without notice. If you have any questions or need assistance with any financial matters relating to your treatment, please contact the spa manager for help.

Signature_____ Date_____

Golden Glow Medical Spa
150 Clearwater/Largo Rd. N Suite 3,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.

The U.S Department of Health & Human Services, Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 or toll free: 1-877-696-6775

Mahajan
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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
"We Create Healthy & Beautiful Skin For All Ages"
150 Clearwater Largo Rd, N, #1, Largo, Fl, 33770
(727)683-0894 Fax (727)518-6511 Email:info@goldenglowmedicalspa.com
Visit us on www.goldenglowmedicalspa.com

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: _____

Mahajan
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Exclusive VIP Beauty Account Membership

Get access to our most desirable treatments and products at the lowest pricing.

NAME:_____ **DATE:**_____

The VIP membership is designed for Golden Glow Medical Spa patients who receive regular treatments to maintain healthy and beautiful skin.

For $75 per month, VIP members can enjoy the following discounted services and benefits:

Botox, Dypsort, & Xeomin - $10 per unit (16.5% savings)
Hydrafacial MD - $125 each (37% savings)
MicroPeel - $75 each (50% savings)
15% off all regular priced skin care products
$100 monthly to use on any regular priced service OR $75 monthly to use towards specials

_____ (Initial) VIP members are prohibited from combining the above benefits with other discounts or promotions. The referred discounts include, but are not limited to monthly specials, holiday specials, gift certificates obtained at a Golden Glow Medical Spa special event, gift cards, etc. VIP account balances may be used towards any full priced service or product.

_____ (Initial) The VIP membership is for a minimum term of 6 months, which will automatically renew unless the member provides Golden Glow Medical Spa with a verbal or written cancelation request at least 5 days prior to the membership renewal date.

_____ (Initial) VIP members may cancel his/her membership prior to the completion of the 6-month contract by providing Golden Glow with a 5 day verbal or written cancelation notice and paying non-refundable fee of $75. This fee may not be deducted from the account balance or paid with gift cards and must be paid at the time of cancelation.

_____ (Initial) The member's account balance will remain active following cancelation, but remaining monies in account may only be used towards regular priced products and services. No refunds will be given.

_____ (Initial) If Golden Glow Medical Spa receives notification of a declined $75 monthly membership payment, the member has 15 business days to pay the missed payment or they will be

dropped from the VIP program and $75 cancelation fee will be deducted from the member's account balance.

_____ (Initial) Golden Glow Medical Spa patients may not join the VIP program if they have canceled VIP membership within the last 6 months.

By signing below, you authorize Golden Glow Medical Spa to charge the account you have specified. Monthly dues will be withdrawn on or after the same day of each month. You understand that Golden Glow Medical Spa may continue to charge your account or cancel your membership in accordance with the terms and conditions of this agreement. Additionally, you authorize Golden Glow Medical Spa to charge your credit card on file in lieu of presenting it for any services received, at your request.

We agree to sell and you agree to purchase the membership, goods and services described herein. You agree to pay us for the membership, goods and services according to the payment schedule above.

Name on Card: _____ Last 4 Digits on Card:_____
CC Expiration:_____

YOU ACKNOWLEDGE RECEIVING AND READING A COMPLETED COPY OF THIS DOCUMENT BEFORE SIGNING. PLEASE ASK A SALES ASSOCIATE IF YOU HAVE ANY QUESTIONS REGARDING THE VIP MEMBERSHIP.

_____ _____
VIP Member Date

_____ _____
Representative Date

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