Health History for Independent Aesthetic Services

Patient Name: ________________________________ Preferred Pronouns:___________ Date:___________
Address: ___________________________________ City: ___________ State: ______ Zip: ___________
Phone: __________________ Cell: ___________________ Email: ______________________________
Date of Birth: ___________________ Gender: Female/Male Do you have Care Credit? Yes No
Emergency Contact Person: _____________________________________ Phone: ___________________

Current State of Health: Good_______ Fair___________ Not Well___________
Are you under a Doctor's Care? Yes NO If yes, doctor's name: ________________________________
What are you being treated for? ____

Have you ever been diagnosed with any of the following?

___ High Blood pressure
___ Auto immune disease
___ Cancer Type: _________
___ Neurological Disorders
___ Myasthenia Gravis
___ Connective Tissue Disorder
___ Photosensitive Disorder
___ Hypothyroidism
____ Heart Disease
____ Stroke
____ Diabetes
____ HIV
____ Herpes/Cold Sores
____ Epilepsy/Seizures
____Glaucoma
____Hyperthyroidism
___ Rosacea
___ Heart Problems
___ Blood Clots
___ Keloids
___Bleeding Disorder
___ Anxiety
___ Hepatitis C
___ Other: ____

Past Surgical History:____
Vaccine History: covid vaccine/booster ___________________ flu vaccine ________________
When in the sun do you: Burn: _________ Burn then tan: ___________ Tan: ________
Last Significant Sun Exposure: ____
Please check all that apply to you:

___Attempting to be pregnant
___ Pregnant
___ Breastfeeding
___ Daily sun block use
___ Birth Control
___ Antibiotics
___ NSAID or pain medication
___ Smoker/Tobacco Use
___ Braces or retainer
___ Pacemaker/Defibrillator
___ Latex Allergy
___ Steroids
___ Metal in body
___ Sensitive to Lidocaine
___ Arthritis Medication
___ Alcohol use
___ Daily Aspirin
___ Accutane use
___ Herbals
___ Benzoyl Peroxide use
___ Vitiligo
___Retin-A use
___ Blood Thinners

Please complete Medications and Allergies below. Please write "none" if you are not taking medications or have any allergies.

Current Medications: ____
Allergies (Drug food):____
Skin Care product used currently (cleansers, soaps, lotions, creams, etc.):

____

What improvements would you like to see on your skin:

____

Patient Name: ____

Patient Signature: ____ **Date:** ____________

Medically Reviewed by: ___________________________________ **Date:** ____________
Omnilux: ____ **ok** ____ **possible sensitivities** _______ **not a candidate**
How did you hear about us: - Internet -Client –Drive by – Radio – FB - Blood Drive-Other_______________

5060 Meadowood Mall Cir.
Reno, NV 89502
775.852.4500

Cancellation Policy & Payment Agreement

The medical staff at Renew MD would like to thank you for choosing us to provide the services and products we offer.

Cancellation Policy
As a busy medical spa, we understand our patient's busy schedules. The medical staff hopes to utilize our schedule to its full capacity and accommodate your schedule as our patient. To ensure effective scheduling for our patients, we have implemented a **48 hour** cancellation/reschedule policy.

Renew MD **requires a 48 hour cancellation/reschedule notice** for all scheduled medical packages & single services. The credit card taken over the phone and/or used for payment is the one we have on file.
If adequate notice is not given for the scheduled appointment, we will charge the credit card on file a fee of $75 to $150.
For repeat no shows additional fees and deposits may be charged.

For all CoolSculpting appointments we require a 48 hour cancellation/reschedule notice, the fee is $250 for no showing or cancelling with less than 48 hour notice. If an emergency arises, please contact Renew MD so arrangements can be made.

Late Policy
As a reminder please run on time for your appointment, if you are running late please call and notify the medical staff that you are running late.
For all medical services: if you do run late, we will utilize the time you have scheduled upon your arrival and you will still be charged for the entire appointment.
For Medical Treatments: if you are running too late and we are unable to accommodate your treatment, it will be considered a no show and a no show fee per appointment will be charged. Thank you for your understanding.

Payment Policy
Payments for all services and/or packages are due at the time of your appointment.
Payments for procedures and/or packages are non-refundable.

By signing below, I certify that I understand and have read all the above policies.

______________________________ ____________
Patient Signature Date

______________________________ ____________
Medical Staff Signature Date

Notice of Privacy Practices

Protecting your confidential health information is important to us
This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Dear patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the Federal (HIPAA—Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want you to delay treatment because you are afraid that your personal healthy history might be unnecessarily made available to others outside of our office.

So what has changed? Why a privacy policy now? Very good questions!
The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in health care. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your healthy information is used within our computers but also with the internet, phone, faxes, copy machines and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere it is used.
We want you to know about these policies and procedures which we developed to make sure your healthy information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.
We will use and communicate your HEALTH INFORAMTION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your health information may be used
To provide treatment
We will use your HEALTH INFORMATION within our office to provide you with the best care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between physicians and/or staff members.
In addition, we may share your health information with physicians, referring specialist, clinical laboratories, pharmacies or other health care personnel providing you treatment.
To Obtain Payment
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed to you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.
To Conduct Health Care Operations
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associated, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.
In-Patient Reminders
Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and restorative care modern medicine can proved. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

Abuse or Neglect
We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.
Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State of Federal law, we may disclose your health information to a law enforcement official for certain law enforcement official purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restriction on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable request for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you would like a copy of your health information please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003, and forwards. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices, we will be sure all our patience's receive a copy of the revised Notice.

You have the right to express complaints to us or the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerts you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

____

Patient Acknowledgment

Patient Name(s):_____________________________________

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you, if not, we would appreciate very much your acknowledging your receipt of our policy by signing this form. We look forward to seeing you again soon!

Patient Signature: ___________________________________

Date:_________/_____/________