NEW MEDI-SPA PATIENT REGISTRATION FORM (please print)

Today's Date: _____ **Primary Care Provider:** _____

Patient's Name: _____ **Maiden** _____
Last, First, MI

Date of Birth (DOB): _____ **Sex: M F**

Marital Status (circle**): Single Married Divorced Separated Widowed**

Mailing Address: _____
Street City, State Zip Code

Home Phone: _____ **Cell phone:** _____

Work Phone: _____ **E-mail Address:** _____

Occupation: _____ **Employer:** _____

Employer Address: _____

Spouse Name: _____ **Spouse DOB:** _____

Day Phone: _____

Emergency Contact (if other than spouse): _____ **Phone:** _____

How did you hear about Family Weight & Wellness Medi-Spa?: (Check one)

☐ Friend: Name _____
☐ Doctor: Name _____
☐ Event: _____
☐ Website: _____
☐ Online: _____
☐ Social Media: _____
☐ Other: _____

Signature _____ Date _____

1230 Rayford Bend, Spring, TX 77386 • Phone 281-292-2300 • Fax 281-367-0605

PATIENT FINANCIAL AGREEMENT

Thank you for allowing our office the privilege of serving your medical needs. Family Weight & Wellness Medi-Spa is a place where the genuine care and welfare of our clients is our highest mission.
That is why it is very important that you completely understand our financial policies. Please read the listed information and contact your account representative or our office at any time with questions.

1. You must remit your payment in full at the time the services are rendered.
   For your convenience, we accept cash, Master Card, Visa, Discover, American Express and CareCredit. ***We do apologize for any inconvenience as we do not accept checks.***
2. Your insurance is a contract between you, your employer and the insurance company. **We are not a party to that contract**. Therefore, you are ultimately responsible for all charges incurred with our office from the date the services are rendered.
3. If any Pre-certifications are required by your insurance company for any testing or treatment, you are responsible to contact them. This is ultimately the responsibility of the patient or insured person, and our office cannot be held responsible.
4. Occasionally, insurance companies require your medical records in order to process our claims. By signing below, you are also authorizing Family Weight & Wellness Medi-Spa to send your complete medical records to your insurance company once they are requested.

Notes:

- If you have any questions regarding our financial policies, please don't hesitate to ask us. We are here to help you.
- By my signature, I certify that I have read and agree to the terms of the above and understand I am fully responsible for any charges incurred.
- A photocopy of this document shall be considered as effective and valid as the original.

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date

Family Weight & Wellness Clinic • Medi-Spa

OFFICE POLICY AGREEMENT

As a patient of Family Weight & Wellness Clinic•Medi-Spa, I agree to adhere to office policies stated below. I understand that these policies are in place to ensure that my care is not delayed or interrupted due to scheduling or financial issues. I also understand they are in place to ensure that the schedules of the health care providers and other patients are not delayed or interrupted.

- I agree to arrive at least 15-20 minutes (or 30 minutes if I am a new patient) prior to my scheduled appointment time to check in and complete or update any patient information forms. As a courtesy to other patients, we request that you arrive on time. If you arrive later than your designated appointment, you may be asked to reschedule.
- I understand that it is my responsibility to provide current and complete personal and medical information, contact addresses and phone numbers, prior to my appointment and on an ongoing basis afterward.
- I understand that all spa-service payments must be paid prior to my appointment and if I am unable to do so, my appointment will be rescheduled.
- If I am unable to keep my appointment, I understand that I must notify Family Weight & Wellness Clinic•Medi-Spa **at least 48 hours before my Medi-Spa** appointment time.
- I understand that if for any reason I do not cancel or reschedule an appointment at least 48 hours prior to the cosmetic appointment, I will be charged a $50.00 fee to my credit card on file.
    - The no-show fees are part of my account balance and must be paid BEFORE my next appointment can be scheduled.
- I understand that I am to remit my payment for services in full at the time services are rendered and that Family Weight & Wellness Medi-Spa does not have a contract with any insurance company and that I am responsible if I would like to submit the paperwork to my insurance provider myself for reimbursement.
- I authorize Family Weight & Wellness Medi-Spa to take pictures of me at any time before, during, and after treatments for purposes of documenting progress.

I agree to adhere to all the above office policies of Family Weight & Wellness Clinic•Medi-Spa.

_____	_____	_____
Name (Printed)	**Signature**	**Date**

No Show / Cancellation policy Effective March 1, 2019

Due to the nature and availability of our practice it is important to us that we have a No show / Cancellation policy in place. This also will give our guests on the waiting list an opportunity to be seen earlier if possible.

Therefore, we require at least a **24 hour notice prior to your wellness appointment or 48 hour notice prior to your cosmetic appointment if you are unable to keep it as scheduled**. If you do not call to cancel your appointment within that 24 hour wellness or 48 hour cosmetic window, there will be a $50 fee charged to your credit card at the end of that business day.

CREDIT CARD AUTHORIZATION:

Patient name: _____

Name on card: _____

CC #: _____

CC type (circle): MasterCard VISA AMEX Discover CareCredit

Exp date: _____ 3 digit code _____

Cardholder signature: _____ Date: _____

By signing, I understand and I have read the No Show/ Cancellation Policy for Family Weight & Wellness Medi-Spa.
This policy will also help us expedite any orders, supplements or cosmetics you may need shipped directly to you from our office the same day the order is placed.

OR

DISCONTINUE CREDIT CARD BILLING:

By discontinuing my credit card authorization, I understand my account will still incur charges as set forth in the No show/ Cancellation policy. Also, as a new guest, with this discontinuation or without a valid credit card on file, I understand I am not guaranteed that my appointment time will be held without confirmation.

Date: _____ Signature: _____

NOTICE TO ALL MEDICARE, MEDICAID, CHAMPUS, WPS &/ OR TRICARE BENEFICIARIES

Family Weight & Wellness Medi-Spa does not participate in Medicare, Medicaid, Champus, WPS or TriCare programs and has chosen to opt out of Medicare. Family Weight & Wellness Medi-Spa has found that due to the minimalistic fees allowed by these government agencies, we are unable to meet overhead expenses. Family Weight & Wellness Medi-Spa is a Free Enterprise and would like to be able to extend quality medical care to you; however, due to the rules instituted by the government of the United States pertaining to these government agencies, the practice is unable to administer medical care to patients covered by them unless you read and sign the attached Waiver.

WAIVER

I understand that Family Weight & Wellness Medi-Spa is not a Medicare, Medicaid, Champus, WPS or TriCare provider and has chosen to opt out of Medicare.

I accept full financial responsibility for any charges incurred.

Further, I understand that by signing this form, I waive my right to seek reimbursement from Medicare, Medicaid, Champus, WPS or TriCare or file any claims to Medicare, Medicaid, Champus, WPS or TriCare for these services. Additionally, I understand that I am unable to file to Medicare, Medicaid, Champus, WPS or TriCare even if it is merely to get a denial in order to file to any other insurance policies.

☐ I do not have Medicare or Medicaid

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date

HIPAA POLICY

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. You have the right to review our notice before signing this consent. The term of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how we protect health information about you if it's used, disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- ❖ Protected health information may be disclosed or used for treatment, payment, or health care operations.
- ❖ The practice has a Notice of Privacy Practices and that the patient has the opportunity to review the notice.
- ❖ The practice reserves the right to change the Notice of Privacy Policies.
- ❖ The patient has the right to restrict the uses of their information, but the practice does not have to agree to those restrictions.
- ❖ The patient may revoke this consent at any time and all future disclosures will then cease.
- ❖ The practice may condition treatment upon execution of this consent.

I authorize Family Weight & Wellness Medi-Spa to release my medical records or insurance information as necessary to process my medial claims and coordinate or manage my health care.

Due to HIPPA, the following information must be updated **by each patient annually**:

HIPAA - ACKNOWLEDGEMENT OF REVIEWOF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Names and Phone/Fax Numbers/Email of individuals who are authorized to receive my medical information:

1 _____

2 _____

3 _____

4 _____

(Circle Y or N)
Y N It is ok to send me an e-mail
Y N It is ok to send me a postcard/flyer/newsletter

For telephone messages on your voicemail or cell phone, please check one of the following:-

1. ____ OK to leave a message re: items such as lab results, vitamins, refills etc.
2. ____ Please do not leave specific message but a general message is OK.
3. ____ Do not leave any messages at all.

_____
Signature of Patient / Parent if minor

_____ _____
Printed Name of Patient Printed Name of Parent if minor

_____ _____
Date Relationship to Patient

Changes to this document must be submitted in writing. This Form is in compliance with HIPPA guidelines. A copy of these guidelines is available upon request.

CONFIDENTIAL CLIENT HEALTH HISTORY FORM

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Business Phone: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Your Health

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?

O No O Yes, explain: _____

2) Any recent surgery, including plastic surgery?

O No O Yes, explain: _____

3) Any skin cancer? O No O Yes, explain: _____

4) Have you had any piercings, tattoos, or permanent cosmetics?

O No O Yes, If yes, where on your person? _____

5) Have you ever had a body spa treatment before? O No O Yes, when: _____

6) Have you had any of these health conditions in the past or present?

(Please check all that apply and provide additional information in the space provided)

Cancer	☐	Headaches (chronic)	☐
Hormone imbalance	☐	Hepatitis	☐
Systemic disease	☐	Herpes	☐
High blood pressure	☐	Frequent cold sores	☐
Spinal injury	☐	Immune disorders	☐

Thyroid condition	☐	HIV/AIDS	☐
Hysterectomy	☐	Lupus	☐
Diabetes	☐	Metal bone pins or plates	☐
Heart problem	☐	Phlebitis, blood clots, poor circulation	☐
Varicose veins	☐	Blood clotting abnormalities	☐
Arthritis	☐	Psychological treatment	☐
Asthma	☐	Insomnia	☐
Eczema	☐	Keloid scarring	☐
Epilepsy	☐	Skin disease/skin lesions	☐
Seizure disorder	☐	Fever blisters	☐
Any active infection	☐		

7) Has your physician discussed concerns about raising your body temperature? O No O Yes
explain: _____

8) Do you smoke? O No O Yes

9) Do you follow a restricted diet? O No O Yes, specify: _____

10) Do you follow a regular exercise program? O No O Yes

11) What is your stress level? High ☐ Medium ☐ Low ☐

List any medications you take regularly: _____

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:

12) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? O No O Yes, describe:

13) Have you used any of these products in the last 3 months? O No O Yes

14) Have you used an acne medication? O No O Yes, when?_____ Which drug? _____

15) Do you form thick or raised scars from cuts or burns? O No O Yes

16) Do you have Hyperpigmentation/darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? O No O Yes, describe: _____

List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

17) Do you experience any problems sleeping? O No O Yes

18) How many hours do you typically sleep each night? _____

19) Do you wear contact lenses? O No O Yes

20) Have you been exposed to the sun or used a tanning bed in the last 48 hours? O No O Yes

21) How frequently are you exposed to the sun or use a tanning bed? __ Infrequently __ Frequently __ Regularly

22) Do you have any metal implants or wear a pacemaker? O No O Yes

23) Have you ever experienced claustrophobia? O No O Yes

24) Do you suffer from sinus problems? O No O Yes

25) Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

26) Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs

Fragrance Shellfish Latex Drugs Other: _____

If yes, please explain: _____

Female Clients Only:

27) Are you taking oral contraceptives? O No O Yes, specify: _____

28) Any recent changes to or from your contraceptive treatment? O No O Yes, If so, what and when?

29) Are you pregnant or trying to become pregnant? O No O Yes

30) Are you lactating? O No O Yes

31) Any menopause problems? O No O Yes, specify: _____

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

_____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____