Medical Spa PMS#____________________

Registration (Please Print)

Date: ______________________ Home Phone: ___________________________ Cell Phone: _______________________

Name: ____ Nickname: ____________________________________

Address: ____

Sex ☐ M ☐ F Age______ Birthdate_____________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Wedding Anniversary ______/______/______

Social Security #:____________________________ Whom may we thank for referring you?: __________________________

Preferred Language:______________________________ Race and Ethnic Group:____________________________________

Employer: ____ Work Phone: ____________________________

Occupation: ________________________ If Student ☐ Full-time ☐ Part-time ☐ Email Address ____________________

(We email out monthly specials, birthday discounts, etc.)

In case of emergency who should be notified? _____________________________________ Phone ______________________

Do we have permission to:

Leave a message on your answering machine?	☐ Yes	☐ No
Leave a message at your place of employment?	☐ Yes	☐ No
Discuss your medical condition with any member of your household?	☐ Yes	☐ No

If yes, Whom:____ Relationship: ___________________________

Are you using any of the following products?

☐ Renova ☐ Glycolic Acid ☐ Benzoyl Peroxide ☐ Accutane ☐ Retin-A

Do you wear contact lenses?	☐ Yes	☐ No
Do you wear dentures?	☐ Yes	☐ No
How much water do you drink per day?	☐ Yes	☐ No
Have you ever received a massage before?	☐ Yes	☐ No
Have you ever received a facial before?	☐ Yes	☐ No
Have you ever received a manicure/pedicure before?	☐ Yes	☐ No

Please take a moment to carefully read the information you have provided to be sure it is as accurate as possible. If you have a specific medical condition or specific symptoms, certain treatments may be contraindicated. Please discuss any questions with your service provider prior to service.

____ ________________ Circle One: Self Parent Guardian

Signature of Patient or Legal Guardian Date

____

Print Name

ADMD ________

A guardian or adult signature is required if patient is under 18

EMA __________

HIPPAA: Patient Consent Form

Name: ____ PMS #: ______________________

Date: ____ Date of Birth:___________________

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 the Consent. The terms 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 protected health information about you is used or disclosed for treatment, payments, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payments,and health care operations. You have the right to revoke this Consent. If you choose to revoke this Consent, you must do so in writing and the document must be signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatments, payments, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- 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 the Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

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Patient/Date Witness/Date