NEW LOOK
HOUSTON

---------- PATIENT INTAKE FORM ----------

Name (Last, First) _____, _____ Today's Date_____

Your Date of Birth: _____ Age: _____ Gender (please circle): *M* or *F*

Address: _____ Apartment # _____ or *N/A*

City: _____ State: _____ Zip: _____

Phone: Mobile: _____ Home: _____ Work: _____

Best number to leave any confidential information regarding your treatment and messages: (please circle) *Mobile* *Home* *Work*

E-mail address (please print clearly): _____

How did you hear about us? _____

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

Occupation/Employer: _____ Hobbies/Activities: _____

Ethnicity (please circle): *Caucasian* *Hispanic* *African American* *Asian*

(Note: Ethnicity, national origin and race may affect how skin reacts to laser/IPL treatment)

Middle Eastern *Pacific Islander* *Other:* _____ *Prefer not to answer.*

Emergency Contact Name: _____ Relationship to you: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

---------- DETAILED MEDICAL HISTORY ----------

[OFFICE USE ONLY]

Skin Conditions (Psoriasis, Eczema, Scars, etc): *NO* *YES* (If YES, explain) _____

Heart Disease (Heart Attack, Palpitations, etc): *NO* *YES* (If YES, explain) _____

Neurological Disease (Seizures, Epilepsy, etc): *NO* *YES* (If YES, explain) _____

Lung Disease (COPD, Asthma, etc): *NO* *YES* (If YES, explain) _____

Liver/Kidney Disease (Cirrhosis, Hepatitis, etc): *NO* *YES* (If YES, explain) _____

Cancer (Leukemia, Lymphoma, Melanoma, etc): *NO* *YES* (If YES, explain) _____

Digestive Problems (IBS, Diarrhea, etc): *NO* *YES* (If YES, explain) _____

Hypertension/Vascular disease (DVT, etc): *NO* *YES* (If YES, explain) _____

Trauma (serious car accidents, injuries, etc): *NO* *YES* (If YES, explain) _____

Infectious Disease (Tuberculosis, STDs, etc): *NO* *YES* (If YES, explain) _____

Immunosuppression (HIV, AIDS, etc): *NO* *YES* (If YES, explain) _____

Endocrine Disorder (Thyroid, Diabetes, etc): *NO* *YES* (If YES, explain) _____

Mental Illness (Depression, Suicide, Bipolar, etc): *NO* *YES* (If YES, explain) _____

Any OTHER medical problems: *NO* *YES* (If YES, explain) _____

List ALL current MEDICATIONS: _____ List ALLERGIES: _____

[OFFICE USE ONLY]: _____ [STAFF SIGNATURE]:_____

(THIS DOCUMENT CONTINUES ON THE NEXT PAGE ➔)

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Do you have an allergy to Bacitracin®, Polysporin®, Neosporin® or any other topical antibiotic cream? *NO* *YES*

Do you have an allergy to any topical anesthetics such as Benzocaine, Tetracaine or Lidocaine? *NO* *YES*

Have you used Accutane®, Claravis®, Sotret® or Amnesteem® (Isotretinoin) in the last six months? *NO* *YES*

Do you have a history of herpes simplex ("cold sores" or "fever blisters") or infection in area to be treated? *NO* *YES*

Female patients only: Are you pregnant or breast-feeding? *NO* *YES*

Female patients only: Do you take any kind of birth control? *NO* *YES*

Last Sun Exposure (tanning / outdoor activity): _____

Do you use tanning beds or spray-on tanning? *NO* *YES* Last exposure: _____

Do you smoke? *NO* *YES* If YES, how much and how often? _____

How does your skin react when exposed to the sun? (please circle only ONE of these six choices below)

Always Burns & Never Tans	Burns Easily & Tans Minimally	Sometimes Burns & Slowly Tans	Burns Minimally & Usually Tans	Rarely Burns & Tans Well	Never Burns & Always Tans

---------- for LASER TATTOO REMOVAL patients only ----------

Number of tattoos you would like to remove: _____ Total number of tattoos you have : _____

Please describe the tattoo(s) you want to remove: _____

How long have you had it? _____ Has it changed over time? *NO* *YES* (if YES, explain): _____

Why do you now want your tattoo(s) removed? _____

Have you tried to remove your tattoo in the past with something OTHER than a laser? *NO* *YES* _____

Have you previously had laser treatment on your tattoo? If YES, when and where? *NO* *YES* _____

Is your tattoo a "cover-up" or a "touch-up" of a previous tattoo? *NO* *YES* _____

Is your tattoo permanent make-up or peach, white, pink or flesh colored ink? *NO* *YES* _____

Female patients: Do you have a breast implant or other augmentation near your tattoo? *NO* *YES* _____

Circle ALL that apply to your tattoo: *Amateur* *Professional* *Cover-Up* *Colored* *Scarred* *Outline Only* *Shading Only*

---------- for HAIR REDUCTION patients only ----------

Which body areas are you interested in having hair reduced? _____

Have you had previous laser hair reduction treatments? *NO* *YES* _____

Has your skin or hair changed in any way recently? *NO* *YES* _____

Why do you want hair reduction treatment? _____

Please describe the hair you want treated: _____

Are you currently using a retinol or retinoid (Retin-A®, Tretinoin, Renova®, Tazorac®, Differin®) or glycolic acid? *NO* *YES* _____

---------- for NAIL FUNGUS REMOVAL patients only ----------

Number of years infected? _____

Any problems with the area besides this? NO YES _____

What other medications, prescription or over the counter have you used? NONE or names of medication _____

What are you currently doing at home (home remedies)? NONE or _____

Have you seen a physician in the past about this matter? NO YES _____

(THIS DOCUMENT CONTINUES ON THE NEXT PAGE ➔)

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---------- POLICIES, PROCEDURES, AGREEMENTS and CONSENTS ----------

The next two pages are intended to provide you with detailed information about our policies, programs, agreements and consents. Please read each section thoroughly, make sure any concerns are addressed and that any questions you have are answered before making your final decision to move forward with the treatment process.

---------- HIPAA PATIENT CONSENT ----------

- Our office is committed to protecting the privacy of your medical information. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (and updated in 2013) is a federal law that governs the use and disclosure of a person's health information. 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. The following statements cover the basics of your rights as a patient under HIPAA:

- Our office has a "Notice of Privacy Practices" and you have the right to review a detailed copy of our Notice before signing this HIPAA Patient Consent.
- This "Notice of Privacy Practices" is available in our offices.
- Protected health information may be disclosed for treatment, payment, or health care operations.
- We reserve the right to change the terms of our "Notice of Privacy Practices" at any time.
- If we change our Notice, you may obtain a revised copy by contacting our office.
- You have the right to restrict the uses of your protected health information.
- You may revoke this HIPAA Consent in writing at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Additionally, it is the policy of this office to remind patients of their appointments. We may do this via live telephone calls, automated (TeleVox) appointment reminder calls, text messages, e-mails, U.S mail, social media or by any means convenient to the practice. We may also send you other communications informing you of changes to office policy, new technology and specials that you might find valuable or informative. That said, contact will only come directly from us; we will never sell or trade your private information including phone numbers, e-mail address or mailing addresses. You may opt out of any or all communication measures any time by contacting us in writing.

By signing the next page of this document, you certify that you have read our HIPAA Patient Consent and have had the opportunity to review a more detailed version if so desired. Your signature also signifies that you agree with the above statements and this policy. NEW LOOK AESTHETICS provides this form and information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (updated in 2013).

--- TELEHEALTH (TELEMEDICINE) CONSENT and VIDEO/PHOTO AGREEMENT ---

My signature below certifies that I understand, agree and consent that NEW LOOK AESTHETICS and its employees, independent contractors, associates, agents and representatives (collectively and hereby known as, "NEW LOOK AESTHETICS ",) may take photographs and/or use video (for "store & forward" or teleconferencing technology) of the area to be treated before initial treatment begins & at some or all reoccurring visits (genital area photos and videos are usually NOT taken). These recordings will be available only to our medical staff members to assess the patient and track the progression of each treatment and are part of the medical record. NEW LOOK AESTHETICS follows extremely strict HIPPA guidelines regarding patient confidentiality and privacy & therefore names and recordings are used internally and only the treated area/area to be assessed will be shown in these photographs & videos.

(THIS SHEET CONTINUES ONTO THE NEXT PAGE)

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---------- APPOINTMENT POLICY ----------

I understand that NEW LOOK AESTHETICS strives to treat all patients at their scheduled times and that I must provide 24 hours notice if I need to reschedule or am unable to arrive to my appointment on time. I agree to pay a $50.00 "no show" / "late cancellation" fee if I miss an appointment or do not give 24 hours notice of a cancellation and I completely understand that I will be billed for each missed appointment or late cancellation and that I cannot receive treatment until this fee is paid. I completely understand that I will not be eligible for participation in the tattoo removal guarantee program and hair maintenance program if I miss multiple appointments or am frequently late. Additionally, a credit card will be required to book and hold future appointments or I will only be able to book "same day" appointments. I also understand that my appointments may have to be postponed or rescheduled on occasion due to unforeseen equipment maintenance and while NEW LOOK AESTHETICS will attempt to accommodate my appointment requests the day, time and clinician I request may not be available.

---------- FINANCIAL RESPONSIBILITY POLICY ----------

My signature below certifies that I hereby seek the services of NEW LOOK AESTHETICS, and its employees, independent contractors, associates, agents and representatives (collectively and hereby known as, "NEW LOOK AESTHETICS ",) for laser, collagen induction therapy and/or dermatological care. I understand that microneedling and laser treatments, such as tattoo removal, hair reduction, are voluntary procedures and are not covered by Medicare, Medicaid, Medi-Cal, HMO, PPO, or private insurance plans. I understand that NEW LOOK AESTHETICS will not submit any claims to any insurance carriers. I understand that payment is due before services are rendered. I also understand and agree that if I pay for a package of services using a credit card, check or finance company and the payment is not honored or is subject to a chargeback at any time for any reason that I am still fully responsible for payment for the treatments I receive and agree to pay for them at the undiscounted ("pay as you go") rate. I agree to pay a fee of $50.00 for each check or charge that is not honored by my bank. I also acknowledge that if I purchase a package of services and I wait more than one year between treatments the package will be deemed to have expired at the one year anniversary of my last treatment, however this will not apply if the delay in treatment is prearranged with the clinic manager, is due to pregnancy or is due to military leave where allowed by law. Lastly, I fully acknowledge that I am personally responsible for all fees and charges incurred in connection with my purchase and I completely understand that there is absolutely **NO** refunding of any patient fees, payments, charges, credit, gift certificates, product purchases or pre-paid packages.

My printed name and signature below certify that I have provided complete and accurate contact and medical information and that I read, fully understand and completely agree with the Tattoo Removal Guarantee and Hair Maintenance Program, HIPAA Patient Consent, the Telehealth (Telemedicine) Consent and Video/Photo Agreement, the Appointment Policy and the Financial Responsibility Policy contained in this four page document.

✖ _____	✖ _____
PRINTED NAME OF PATIENT	**TODAY'S DATE**
✖ _____	
PATIENT SIGNATURE (or signature of legal guardian if patient is under 18)	This space for office use only (Staff Signature)