CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, please complete the following questionnaire. Information Provided is Confidential.

PERSONAL HISTORY

Client First & Last Name:_____ Today's Date: _____

Date of Birth:_____ Age:_____ Occupation:_____

Home Address: _____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address: _____

Emergency Contact:
Name:_____ Phone:_____ Relationship:_____

How were you referred to us? _____

PROCEDURES THAT INTEREST YOU

Please put a check mark next to the services that interest you.

_____ Botox
_____ Fillers
_____ Photofacial
_____ Chemical Peel/Facial
_____ Fractional
_____ Skin Resurfacing
_____ Skin Tightening
_____ Cellulite Reduction
_____ Laser Hair Removal
_____ Scar/Stretch Marks
_____ Acne Treatments
_____ Tattoo Removal
_____ Laser Liposuction (Non-Surgical)
_____ Liposuction (Surgical)
_____ Hormone Program
_____Other (please specify) _____

MEDICAL HISTORY

Are you currently under the care of a physician and/or dermatologist? _____Yes _____No

If yes, for what:_____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? _____Yes _____No

If Yes, please explain: _____

Do you have any of the following medical conditions? (Please check all that apply)

_____Cancer _____Diabetes _____High blood pressure _____Herpes _____Arthritis

_____Frequent cold sores _____HIV/AIDS _____Keloid scarring _____Skin disease/Skin lesions

_____Seizure disorder _____Hepatitis _____Hormone imbalance _____Thyroid imbalance

_____Blood clotting abnormalities _____Multiple Sclerosis _____Any active infection

_____Other medical conditions/problems? Please list: _____

Do you have any dental work such as veneers, or dental implants?_____

Do you have any piercings, dermal implants, tattoos? Please list:_____

Have you ever had an allergic reaction to any of the following?
(Please check all that apply and describe the reaction you experienced)

Food_____ Latex _____ Aspirin_____ Lidocaine_____ Hydrocortisone_____

Hydroquinone or skin bleaching agents_____ Others_____

MEDICATIONS

Have you ever used (circle): Accutane or Retin-A® ?

If yes, when did you last use it? _____

What oral medications are you presently taking? (Please list)

_____

What topical medications or creams are you currently using? (Please list)

_____

SKIN HISTORY

Which of the following best describes your skin type? (Please check only one)

_____ Always burns, never tans

_____ Always burns, sometimes tans

_____ Sometimes burns, always tans

_____ Rarely burns, always tans

_____ Brown, moderately pigmented skin

_____ Black skin

Have you ever had laser hair removal? _____Yes _____No

Have you used any of the following hair removal methods in the past six weeks?

___Shaving ___Waxing ___Electrolysis ___Plucking ___Tweezing ___Threading ___Depilatories

Any recent tanning or sun exposure that changed the color of your skin? _____Yes _____No

Have you recently used any self-tanning lotions or treatments? _____Yes _____No

Do you form thick or raised scars from cuts or burns? _____Yes _____No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? _____Yes _____No

If yes, please describe: _____

Have you recently had any Botox or filler? _____Yes _____No

FOR OUR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? _____Yes _____No

Are you breastfeeding? _____Yes _____No

Are you using contraception? _____Yes _____No

SIGNATURE

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the Technician, Esthetician, Therapist, Doctor or Nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to give the best care and execute appropriate treatment procedures.

Signature: _____ Date: _____

CONDENSED HIPAA NOTICE OF PRIVACY PRACTICES

Your health is a serious personal matter and we understand that confidentiality is of utmost importance. To ensure your complete privacy, we implemented and follow specific strict security protocols and processes.

The Department of Health and Human Services has established a "Privacy Rule" to help insure that the privacy of your personal health care information is protected. Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information and information about treatment, payment or healthcare operations, in order to provide healthcare that is in your best interest.

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. We may also disclose protected health information to other physicians who are treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give your consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Representatives.

You have the right to review our complete HIPAA Notice of Privacy Practices that is posted at our front desk. You have the right to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

If you feel that your privacy rights have been violated you may contact us and ask for the Director of Operations. The director will investigate all claims and will provide you with a written report of their findings within 10 days. If you are not satisfied with the report and corrective action taken, the Director will provide you with an appropriate state or federal organization address and/or telephone numbers to file a complaint.

Patient name (Please Print): _____ Date of Birth:_____

Patient Signature: _____ Date: _____

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PHOTO/VIDEO RELEASE

I grant to Pynch Medical, and those acting under its permission or authority (collectively, "Photographer"), in connection with any and all photographs and video footage that Photographer may take of the Subject listed below, the irrevocable royalty-free right and permission to copyright, publish, modify, use and reuse such photographs/footage and my name (collectively, "Likeness") in any and all media now known or hereafter devised, worldwide, in perpetuity, for advertising, promotion, endorsement, trade, exhibition, distribution, or any other lawful purpose whatsoever. I agree to assign and hereby assign any ownership rights I may have in such photographs and waive any rights, including but not limited to any moral rights, I may have in such photographs/footage. I acknowledge that I will not receive any compensation as a result of any use of my Likeness and agree not to make any claim against Photographer as a result of any use of my Likeness, including, without limitation, any claim that such use invades any right of privacy, publicity and/or personality, defamation, libel, and any other personal and/or property right.

Please initial one of the following:

_____ I hereby acknowledge and represent that I am over the age of eighteen years and that I have read and understand this release.

_____ I hereby acknowledge and represent that the Subject is a minor and that I am the parent or duly authorized representative of the Subject and that I have read and understand this release.

Signed this _____ day of _____, 20__

Name of Subject (please print): _____

Signature of Subject or Guardian: _____

Name of Person Signing (if for minor): _____

PYNCH Policies

Appointment Policy

We ask that you please arrive 10-15 minutes prior to your appointment time. We will do our best to accommodate late arrivals. However, the length of service may be adjusted so as to not interrupt the scheduled appointments of other guests.

Cancellation Policy

Your treatments are reserved especially for you. We value your business and ask that you respect PYNCH Medical scheduling policies. If you need to cancel or reschedule, please notify us at least 24 hours in advance. Any cancellations with less than 24 hours of notice are subject to a cancellation fee of $25. Clients who no show for appointments without giving any prior notification are subject to pay up to 50% of the scheduled service. When you schedule your appointment with us, you are agreeing to these policies.

For the safety of your children, PYNCH Medical does not allow any children under the age of 16 in the clinic unless they are receiving services with an adult.

Refund Policy

Injectables

All injectable treatment sales (Botox, Juvederm, Radiesse, Restylane, Sculptra and others) are final; refunds or credits cannot be offered once treatment is completed.

Treatments & Packages

Once services are purchased they will not be refunded, however, to ensure our clients always receive the greatest experience at PYNCH, unused service values (cash equivalent for the remaining amount of a treatment package) can be applied to any other service at PYNCH. To avoid abuse of special discounting with treatment/service packages, refunds on remaining un-used treatments will be given only after applying the full standard price of used treatments. All service packages and pre-paid treatments must be used within 6 months of date of purchase or they will expire.

Clients who have purchased our services from third parties (Groupon, LivingSocial, etc.) need to check the third party voucher for terms and conditions, as the terms or conditions of the deal/voucher will apply. Since third party entities are paid directly by the client, PYNCH cannot refund purchases made via a third party. However, notwithstanding the voucher terms of any third party, patients who are unsatisfied with the purchase, may redeem the remaining unused portion of the voucher for another service currently offered at PYNCH. Services that have already been rendered will not be redeemed again.

Products

We are constantly striving to create an environment founded in excellence, quality, and most importantly – the safety of our clients. For this reason, we cannot accept skin care product

returns (with exception to clear defects in packaging or product) once your purchase has been completed.

Gift Certificates

Gift certificates are non-refundable. We will, however, allow them to be transferred to another party.

Cancellation policy

We ask that you please arrive 10-15 minutes prior to your appointment time. We will do our best to accommodate late arrivals. However, the length of service may be adjusted so as to not interrupt the scheduled appointments of other guests.

Cancellation Policy:

Your treatments are reserved especially for you. We value your business and ask that you respect Pynch Medicals scheduling policies. If you need to cancel or reschedule, please notify us at least 24 hours in advance. Any cancellations with less than 24 hours of notice are subject to a cancellation fee of $25.

Clients who miss their appointments without giving any prior notification are subject to pay up to 50% of the scheduled service. When you schedule your appointment with us, you are agreeing to these policies.

_____

Name

INFORMED CONSENT FORM FOR LASER/IPL THERAPY

I understand that a LASER/IPL is being used for a treatment on me under the direction of NALA MED SPAS. Although LASER/IPL therapy is safe and effective in the majority of cases, unexpected adverse events may occur. Unexpected side effects may result from the use of the laser, and the expected response of the treated area may not be achieved.

_____ 1. **Short term effects:** I understand there are multiple short term effects that may occur with LASER/IPL therapy, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, blistering, scabbing, crusting, flaking, and sensitivity to the sun. Although these effects typically resolve within several days, they may persist for several weeks and rarely, even longer. I understand that the degree of the side effects varies from person to person, and it may not be possible to predict how I will respond.

_____ 2. **Possible permanent effects:** I understand that although most side effects are short term and resolve fairly quickly, some effects may be permanent. Scarring and changes in pigmentation (lighter skin or darker skin) may be permanent.

_____ 3. **Discomfort associated with procedure:** I understand that the LASER/IPL functions by heating up its target (blood vessels, pigmentation). This heating sensation may be minimized by the use of the cooling device, but some level of discomfort may be felt. The level of discomfort depends on the treatment being done, and varies from person to person. The stinging or sensation of heat is typically short term but may persist for several hours after the procedure.

_____ 4. **Effects of UV:** I understand that sun exposure, tanning beds, sunless tanning lotions, and tanning creams can cause discoloration or reaction to LASER/IPL treatment during and after the procedure. Having any kind of tan prior to therapy or soon after therapy results in an increased chance of blistering, permanent or temporary discoloration, scarring, and discomfort. I understand that avoidance of any UV exposure 1 month prior and 2 weeks after treatment reduces the risk of these effects.

_____ 5. **People excluded from therapy:** I understand that certain patients should not have LASER/IPL treatment. This includes any patients who have sun exposure in treatment area, open wounds, malignant skin tumors, patients who have certain disease that make them sensitive to light, patients currently on Accutane, Isotretinoin, Sotret, Claravis, Amnesteem or who have been on Accutane, Isotretinoin, Sotret, Claravis, Amnesteem within in the last 3 months, and in many cases, patients who have tattoos in the area to be treated.

_____ 6. **Need for multiple treatments:** I understand that many conditions being treated by the LASER/IPL will require multiple treatments to obtain the desired results. For laser hair reduction, the procedure works by targeting growing hair follicles, not dormant hair. Complete destruction of all hair follicles with a single treatment is therefore not possible, and multiple treatments are necessary. For redness/rosacea, results are seen after the first treatment, but multiple treatments are often necessary to remove the desired amount of redness/blood vessels, and multiple treatments are often necessary to smooth a blotchy appearance that may be present after 1 treatment. Everyone responds in different ways and different rates to the treatment.

_____ 7. **Tattoo/permanent makeup:** If there are any tattoos or permanent makeup in the area, there is a possibility of blistering and lightening of the tattoo/makeup.

_____ 8. **Photographs:** I understand that the physician/technician may choose to take photos of my treatment area for the purpose of monitoring my progress.

_____ 9. **For permanent hair reduction:** I understand that there are other options for permanent hair reduction such as electrolysis, waxing, and chemical preparations. I understand the difference between these options and permanent hair reduction, and I am choosing LASER/IPL as a noninvasive treatment for my hair epilation. I also understand that the hair follicles that are treated are permanently destroyed, and may not grow back (this is especially important when treating certain areas such as the neck, beard/moustache area, scalp). Use of the laser is FDA cleared for permanent hair reduction, and it is possible that new hairs will grow at some point in the treated areas. Response to treatment varies from patient to patient.

_____ 10. **For laser vein treatment:** I understand that this procedure involves a laser to coagulate the vessels and a bruising effect could last up to 6 months. It is possible the results will be minimal or not help at all. I realize that each individual's treatment response is different; therefore it could require multiple treatments to achieve desired results. Other options are available, and may include sclerotherapy and surgery.

_____ 11. **For non-ablative LaserFacial:** I understand that erythema (redness) is a common immediate reaction from the LaserFacial treatment process. This typically resolves in 2 hours, but may last longer. I understand that 4-6 treatments are required for the non-ablative LaserFacial to be most effective, and it is important to follow the recommended maintenance schedule for future treatments to keep the best possible results. I also realize that each individual's treatment response may be different, and the number of treatments may vary to achieve desired results.

_____ 12. **For laser treatment of redness/rosacea:** I understand that this procedure for reduction or elimination of redness/telangectasia/rosacea could result in a bruising effect that could last 2-3 weeks. It is possible that the results will be minimal or not help at all. Each individual's treatment response is different; therefore it could require multiple treatments to achieve the desired results.

_____ 13. I understand that my insurance company will not cover the cost of laser therapy, and I am responsible for the complete cost of the service. Payment is due at the time of the treatment. I also understand that once I have started my treatment program, there are no refunds.

_____ 14. I have received, read and understand the post-treatment instructions.

I have been explained the nature and purpose of the LASER/IPL treatment, including any risks and possible complications, and has discussed the contents of this form with me. I have read and understand this consent form, and I agree to its terms and authorize treatment. I further understand that there are no guaranteed results. I will not hold NALA MED SPAS or the employees responsible for my individual results.

Patient name (Please Print): _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____