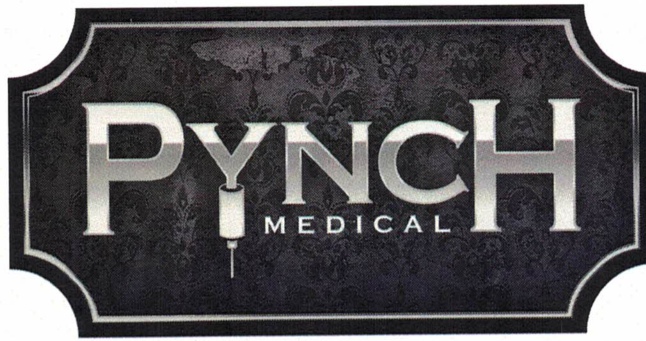


CLIENT INFORMATION & MEDICAL HISTORY

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.

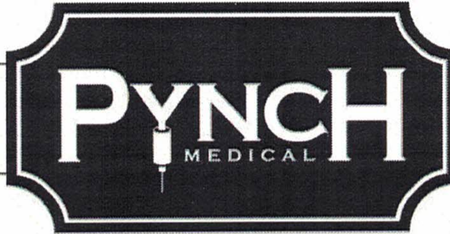
You have the right to review our complete HIPAA Notice of Privacy Practices that is posted at our front desk. You have the right to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

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: ____________

11000 N Scottsdale Rd Suite 180
Scottsdale, AZ 85254



Main Office 602.247.8644
www.PynchMedical.com

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