Radiance

Client Profile

Name: _____ Sex: ____ Age: ____ Date of Birth: _____

Address: _____ Daytime Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

Email Address: _____ Today's Date: _____

How did you hear about Radiance or who referred you? _____

Emergency Contact:_____ Phone: _____

Have you ever been treated for: (Check all that apply)

☐ AIDS/HIV	☐ Allergies/hay fever	☐ Dizziness/fainting	☐ Seizures
☐ Skin rash/disease	☐ Asthma or wheezing	☐ Bleeding problem	☐ Eye problem
☐ Heart problems	☐ Lung Problems	☐ Nervousness/Anxiety	☐ Back pain
☐ Cancer	☐ Tuberculosis	☐ Claustrophobia	☐ Arthritis
☐ Diabetes	☐ Varicose Veins	☐ Drug/alcohol addiction	☐ Head Injury
☐ High blood pressure	☐ Low immunity	☐ Severe Headaches	☐ Cold Sores

List any other diseases or illnesses you have had:

_____

List all prescription and OTC Medications you are currently using or have recently used:

☐ Heart ☐ Thyroid ☐ Blood Pressure ☐ Vitamins ☐ Tazorac ☐ Cold/Allergy
☐ Insulin/other diabetic meds ☐ Antidepressants/ Anxiety Meds ☐ Herbal/nutritional supplements
☐ Retin-A/Renova/Differin ☐ Hydroquinone ☐ Testosterone/estrogen ☐ Antibiotics
☐ Accutane-when stopped _____ Others: _____

Do you drink alcohol? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Do you wear contact lenses? ☐Yes ☐No
Have you ever had a cold sore? ☐ Yes ☐ No If yes, explain: _____
Do you require antibiotics when you go to the dentist? ☐ Yes ☐ No
WOMEN ONLY Date of Last Menstrual Period _____ Are you pregnant? ☐Yes ☐No Due Date:_____

Previous Cosmetic Procedures:

Waxing/electrolysis/use depilatories? ☐ Yes ☐No When & What kind? _____
Microdermabrasion ☐ Yes ☐ No When & How often? _____
Laser Resurfacing ☐ Yes ☐ No When? _____
Dermal Filler Injection ☐ Yes ☐ No When & Which type? _____
Botox Injection ☐ Yes ☐ No When? _____
Chemical Peel ☐ Yes ☐ No When & What kind? _____
Facial or Cosmetic Surgery ☐ Yes ☐ No Describe: _____

Allergies:

List: _____
Have you ever had a bad reaction to any skincare products? _____ Describe: _____
Have you ever seen a dermatologist for your skin? _____ If yes, why? _____

Skin Description:

Describe your ethnic background: _____
Do you use sunscreen regularly? ☐ Yes ☐ No Do you use tanning booths or lotions? ☐ Yes ☐ No
How do you tan? _____ Do you burn easily in the sun? ☐ Yes ☐ No
Have you or anyone in your family had skin cancer? ☐ Yes ☐ No Describe: _____
Describe your current skincare regimen: _____

Desired Improvements:

Current appearance problems/goals that brought you to Radiance Medspa:

_____

_____ _____

Client Signature/Date **Clinician Signature/Date**

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medspa

Notice and Acknowledgement of Privacy Policy and Procedures

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), Radiance Medspa may not use or disclose your personal health information without your authorization.

THE PRACTICE HAS POLICIES AND PROCEDURES TO COMPLY WITH HIPAA LAW. EVERY ATTEMPT HAS BEEN MADE TO KEEP THE PROCESS FOR PATIENTS AND STAFF AS EFFICIENT AS POSSIBLE. HOWEVER, THE REQUIREMENTS ARE EXTENSIVE AND TAKE TIME, EFFORT AND COOPERATION TO PROCESS REQUIRED TASKS.

All patients are presented with certain notices and must sign certain forms. Depending on the course of treatment, some patients may be required to sign additional forms. The following is a summary of the most common notices and forms:

Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Authorization for Use or Disclosure of Protected Health Information: The Practice may not use or disclose your health information for purposes other than treatment, payment or health care operations, without your authorization. Your signature on this form indicates that you are giving permission to the people listed on the form, for the use and disclosure of the health information listed on the form, for the purposes on the form, to the people/organizations listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

Complaint: You have the right to complain about the Practice's privacy policies, procedures or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint.

Request to Amend Protected Health Information: You have the right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. The Practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

Request for Inspection of Protected health Information: You have the right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain the reason why the request will not be granted. In the event that your inspection request is not granted, you may request that the decision be reviewed by someone other than the person who denied the request.

Request for Accounting of Disclosures of Protected Health Information: You have a right to request an accounting of disclosures of health information that pertains to you.

Confidential Channel Communications Request: You have the right to request that communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.

Designation of Personal Representative: You have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By making this request, you are informing the Practice of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have received and read the above Notice of Privacy Policy and Procedures and that I have had any questions regarding this notice answered to my satisfaction.

_____ _____

Patient/Patient Representative Signature Print Name

_____

Date

_____ _____

Radiance Medspa Representative Signature Print Name

_____

Date