AGELESS

BEAUTY CENTER

Name _____

Birth Date_____/_____/_____ Sex M F

Address_____ City/State/Zip_____

Home Phone_____ Cell Phone_____

Are we able to call you at work? Y N If yes, Work Phone_____

Email Address_____

Are we permitted to email specials or notices of events? Y N

Emergency Contact_____ Relationship_____

Emergency Contact Phone_____

Are you allergic to any medications? Y N

If yes, please list: _____

_____

_____

How did you hear about us? _____

All procedures performed at the Ageless beauty Center are cosmetic in nature and are not ones payable by medical insurance. Payment for all procedures is expected at the time of service, and no bill will be sent. The Ageless Beauty Center will accept cash, checks, and credit/debit cards as acceptable forms of payment. All returned checks will be subject to a **$30.00 fee**.

I certify that I have read the above notice and understand the payment policy of the Ageless Beauty Center. In addition, I also certify that I have received a copy of the Ageless Beauty Center Notice of Privacy Policies.

_____ _____

Signature **Date**

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How do you feel about your overall quality of skin?

Not Happy 1 2 3 4 5 6 7 8 9 10 Love It

What are your specific skin concerns?

__Oily/Shiny/Large Pores	__Dull	__ Fine Lines	__ Rosacea
__Uneven Skin Tone /Hyper pigmentation	__ Dry	__ Crepe/Loose Skin	__Deep Wrinkles
__Blackheads/Whiteheads/Malia	__ Flaky	__ Sensitive	__Scarring
__Breakouts	__ Tight	__ Redness	__ Melasma
__Acne (constant)		__Broken Capillaries	__Dark Puffy Eye

Other_____

What skin care products are you currently using at home?

__Cleanser	__Exfoliate/Scrub	__ Day Moisturizer	__ Serums	__Retin- A
__Toner	__Mask	__Night Moisturizer	__ Eye Cream	__SPF

Do you take supplements/vitamins? Yes_____ No_____

Heritage (Parents and Grandparents)

_____

_____

What are your goals you would like to accomplish with your skin?

_____

_____

_____

_____

YES	NO	Medical Information
☐	☐	Accutane or other similar medication
☐	☐	Autoimmune disease, HIV, lupus, hepatitis, scleroderma
☐	☐	Blood thinners – Heparin, Coumadin, Warfarin, Daily Aspirin/NSAID or Vitamin E, etc.
☐	☐	Breast feeding, pregnancy
☐	☐	Cancer or post-cancer treatments
☐	☐	Cardiovascular problems
☐	☐	Cold sores or fever blisters without pre-medication
☐	☐	Cortisone or steroid injections
☐	☐	Cosmetic injections, fillers or implants, (i.e. Botox®, collagen)
☐	☐	Eczema, psoriasis
☐	☐	Enlarged or painful glands
☐	☐	Epilepsy
☐	☐	Facial waxing services w/in 7-14 days
☐	☐	Heart ailment
☐	☐	Hypertension/high blood pressure
☐	☐	Inflammatory conditions
☐	☐	Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
☐	☐	Keloids, pigmented scars, icepick scars, new scar tissue
☐	☐	Laser procedures, chemical peels, dermabrasion, microdermabrasion
☐	☐	Light sensitive medication

YES	NO	Medical Information
☐	☐	Loose, thin, aged skin
☐	☐	Lymphatic disorder, inflammation of lymph vessels, lymphedema
☐	☐	Medication, list here:
☐	☐	Phlebitis, varicose veins
☐	☐	Recent accident or serious injury
☐	☐	Recent surgical or dental procedure
☐	☐	Rosacea, telangiectasia/couperose
☐	☐	Retin-A, Retinol
☐	☐	Skin abrasions or lesions
☐	☐	Stage III or IV acne
☐	☐	Skin-lightening or bleaching agent
☐	☐	Sunburn
☐	☐	Swollen or infected tonsils
☐	☐	Thyroid conditions
☐	☐	Type I diabetic
☐	☐	Under medical care for an existing or suspected condition or disease
☐	☐	Viral infection, influenza
☐	☐	Other contraindication at discretion of skincare technician or medical practitioner:

Client Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

This notice of Privacy Practices describes how we may use and disclose your protected health/personal information (PHI) to carry out our treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected information. "Protected health/personal information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health/Personal Information

You protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you to support business operations of this office, if requested by you to a finance company to pay for your care, and any other use required by law.

Treatment: We will use and disclose your protected health/personal information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health/personal information as necessary if, as a result of our services, you require treatment by a physician. Your protected health/personal 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.

Payment: Your protected health/personal information will be used, if requested, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health/personal information in the following situations without you authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors and organ donation, research, criminal activity and national security, workers' compensation, inmates, required uses and disclosures. Under the law, we must make disclosure to you and, when required by the Secretary of the U.S. Department of Health and Human Services, to investigate or determine our compliance with the requirements of the Standards for Privacy of Individually Identifiable Health Information set forth at 45 C.F.R. parts 160 and 164.

Other Permitted and Required Uses and Disclosures will be made only with your written authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization.

Initials_____

Date_____

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We reserve times in our schedule for you and only you; therefore there is a **$50.00** fee for no-show appointments and cancellations made less than **24 hours** in advance of the appointment. All new patients will be asked for a credit card number to reserve their first appointment. The credit card will not be charged unless a **24 hour** notice was not given upon cancellation or a now-show was ensued. Any Patient that arrives more than **15 minutes** late for an appointment may experience a delay in their service or may need to reschedule. If your appointment needs to be rescheduled the appointment will be seen as a no-show and a **$50.00** fee will be charged. Payment is due on all services and products obtained at time of service. There will be a **$30.00** charge for all returned checks. Failure to meet your financial obligations may result in a collection action for your account balance. This may include but not limited to the account being turned over to a collection agency, reported to a credit bureau, a claim filed for a judgment in small claims court. Once the account is placed in collection status, your future services at Ageless Beauty Center will be suspended. All outstanding patient account balances must be paid in full before your next visit or your appointment will be rescheduled. Your account will then be on a cash, credit card, or money order basis only. All attorney fees, court costs, and other expenses that relate to collecting your account will be added to your outstanding balance. The adult accompanying a minor and the parents (guardians of minor) are responsible for full payment. Unresolved accounts will result in the account being sent to collections, regardless of who is responsible for the balance due. If an overpayment is made by you on the account, a refund or credit towards your next service or product purchase will be issued as long as there are no other outstanding debts on any accounts which are under your responsibility. It is your responsibility to inform us of any changes in address, phone number, medical history, surgeries, cosmetic procedures, skin care regimen, professional skin care treatments, and medications taken.

_____ _____

Signature **Date**