

Rejuv Medical Patient Demographics

First Name: _____ Last Name: _____

Sex (Circle): Male or Female DOB: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

Email: _____

Cell Phone: _____ Home Phone: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Marital Status: _____ Employer: _____

Occupation: _____ Work Phone: _____

Employment Status (Circle): Full-Time Part-Time Disabled Retired Student Not-Employment N/A

Race (Circle): White Black/African American American Indian Asian Other

Ethnicity (Circle): Hispanic/Latino Not Hispanic or Latino Asian Other

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Please Initial The Statements Below:

___ Rejuv Medical cannot guarantee insurance coverage by your insurance provider

___ I certify that the information I am providing is true and correct. I understand and agree that I am ultimately responsible for payment that may not be covered by my insurance.

___ I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

Signature: _____

(Patient/Responsible Party Signature)

(Date)

Notice of Privacy Practices



Acknowledgement of Receipt of Notice of Privacy Practices

The Notices of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Rejuv Medical's health care operations. The Notice of Privacy Practices also describes my rights and Rejuv Medical's duties with respect to my protected health information. The Notice of Privacy Practices is available from your therapist.

Rejuv Medical reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority



Patient Name: _____

The consent to treatment form explains the risks and benefits of the Contour Light treatments. Patients understands the following:

1. Results vary greatly from person to person. No result is guaranteed.
2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.
3. Temporary hyper pigmentation/ hypo pigmentation (changes in skin color) on rare occasion may occur as a result of treatment.
4. Contour Light should not be used by patients with any of the conditions listed below:

Conditions that Prevent Treatment

Patients agrees (by Initialing) that all of the following are true:

_____ I am over the age of 18

_____ I do not have and never had any of the following medical conditions:

- Cancer (active or within 1 Year of remission)
- HIV/ AIDS
- Hepatitis C or D
- Uncontrolled High Blood Pressure

_____ I am not pregnant or breastfeeding

_____ I do not have a pacemaker

Signature:

By signing below, patient agrees that provider listed above may perform the Contour Light procedure for the purpose of body contouring.

Patient understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of the patient's knowledge.

Patient Signature _____ Date _____

DISCLOSURE TO THIRD PARTIES (OPTIONAL)

By signing below, patient agrees to permit provider and third parties authorized by provider to use patients' name, photos and/ or videos in the marketing of the Contour Light system and procedures. Absent a signature, provider will not disclose patient's identity to any third party except as required by law.

Signature _____