New Patient Intake Form

Name: ___________________________________ Phone/Cell_____________________

Address: _________________________________ City:_______________________

State: _______________ Post code: ________________

Date of Birth: ______________________ Sex: F/M:________________

Email: ____

Height _____________ Weight____________

Emergency Contact: ____________________________________

Phone/cell:_______________________ Email:__________________________

Relationship: _________________

Preferred Contact Method: (circle one) Phone Text Email

How did you hear about us: (circle one) Groupon Website Google Facebook Instagram Referral Other_________________

Medical History: Please select the relevant box.

Bleeding disorder □
Bruise easily □
Endocrine / hormone issues □
Diabetes □
Lupus □
Pigmentation disorder □
Defibrillator □
Epilepsy □
Lymphatic/Immune system Disorder □
History of cold sores □
History of keloid □
Inflammation scarring □
History of skin cancer □
Dermatological conditions□
Steroid Therapy □
High blood pressure □
History of cancer □
Are you Pregnant □
Any Abnormal/undiagnosed pigmentation □
Laser resurfacing in treatment area within 3 months: □

List any allergies to food, medications, latex, etc:

____

Are you currently taking any medications or supplements please specify your condition:

____

Currently using or used any of the following in the last 3 months?
Anticoagulants: □ Antibiotics : □ Gold medication: □ Accutane : □ Retin A: □

Has the area which will be treated ever had any of the following:
Chemical peels: □ Botox: □ Injectable Fillers: □ Laser or IPL:□

What Products do you use on your skin? ____________________________________

Have you had any natural sun exposure or used sun beds in the last 4 weeks? Yes □ or No □

Missed Appointment and Cancellation Policy

Please Note: if you are unable to keep a scheduled appointment, please provide 24 hours notice to ensure you will not be charged for the appointment.

Otherwise a **$50 cancellation fee** will be applied to any missed or cancelled appointments within 24 hours of scheduled appointment time.

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CONSENT FOR INTENSE PULSED LIGHT HAIR REMOVAL

I authorize **ALLIED HEALTHCARE PHYSICIAN PLLC** and their staff to perform intense pulsed light treatment upon me for the purpose of long term hair removal..
I understand that Intense Pulsed Light hair reduction is permanent , and that a minimum of six treatments every 4 to 6 weeks on a consecutive basis. Upon completion , I understand that I will be responsible to purchase a touch up series if any additional result is desired. To obtain additional treatments, I will allow the hair to grow out, so that it may be individually targeted by the laser or intense pulsed light. I also understand that there is no guarantee for white, grey, red, red, or blond hair, because their colors cannot be removed by this method.

I understand that I must not be tanned from the sun or artificial tanner at time of treatment and have been truthful about my exposure to the sun and other artificial tanners within the last 6 weeks. I have been told that minor side effects are common and include temporary redness and mild sunburn-like effects, which may last for a few days. Other potential risks include itching, pain, blistering, bruising, infection, scarring, swelling and failure to achieve the desired hair loss. Serious or long lasting effects are very rare . but may include pigment changes, which are light or dark spots on the skin, which may last for several months. I agree to call the office and return to the office for treatment of any side effects or any other problems,at no additional charge.

I consent to photographs being taken during the course of my treatment to evaluate the effectiveness of treatment . Pre -treatment and post treatment instructions have been given to me and the potential advantages and disadvantages have been discussed with me. I have had all of my questions answered and I freely consent to the proposal treatment.
I understand that Laser that Laser ot I intense Pulsed Light Hair Removal is not regulated by the New York Department of State.

Signature : ____

Date: _________________ Name (Print) : _____________________________

Witness :______________________________

1. <u>INFORMED CONSENT .</u> *The purpose of this Informed Consent is to help you decide whether laser hair removal (LHR) cosmetic procedure is right for you and to help you make an informed decision to undergo this procedure. This Informed Consent gives you general information about LHR cosmetic procedures , explains other treatments options, and identifies the benefits, risks , side effects and possible complications associated with LHR procedure.*

2. <u>LASER HAIR REMOVAL PROCEDURE:</u> *LHR is a non-invasive laser treatment designed to remove unwanted hair from all parts of the body. The laser device works by emitting pulses of light energy that penetrate the skin and destroy hair follicles while the device's handpiece cools the surrounding skin Because the laser needs to fill the air follicle to work effectively. It is important not to wax , tweeze, have electrolysis procedures or pluck hair for 2-4 weeks prior to the procedure. You will be required to wear protective eye glasses during the procedure to protect your eyes from the laser light. You may feel a slight burning, stinging or pinching sensation during the procedure .* ***It generally takes 10-21 days after the procedure for the treated hair to fall out.*** *Treatment of dark coarse hair generally achieves the best results while removal of light fine hair generally requires additional treatments which may or may not be successful. Clinical results of LHR may also vary depending on individual skin type, hormonal levels and hereditary influences. Therefore, some patients may experience partial results and some may notice no improvement at all. Future hormonal changes may cause additional hair growth . LHR procedure generally involves a series of treatments . Ideal (light skin /dark hair) candidates can usually achieve 65% - 90% reduction with a series of 6 treatments. Thicker skinned areas such as mens backs , faces or neck usually require more than 6 sessions and usually achieve only partial reduction or hair thinning.*

3. <u>ALTERNATIVE PROCEDURES:</u> *LHR is a voluntary cosmetic procedure which is not necessary or required.*

4. <u>NOT GOOD CANDIDATES :</u> *Generally you are not a good candidate for LHR procedure if you are pregnant , nursing or plan to become pregnant while undergoing LHR treatments . Individuals who have Accutane within the past six months or who used medications requiring limited exposure to sunlight are not are not good candidates for LHR procedure. Individuals with recently tanned skin are advised to delay undergoing the LHR procedure. The laser may not be effective on blond or gray hair. Sun exposure 2-4 weeks prior to treatment may reduce effectiveness of the laser. It Is important to shave the area prior to the treatment session. (We do not provide shaving services as you must do this yourself prior to the treatment). Please inform us if you have an allergy to Aloe.*

5. <u>RISKS AND COMPLICATIONS:</u> *All medical and cosmetic procedures are associated with certain risks and may result in complications. Possible risks and complications associated with LHR procedure include :*

- a. *temporary , bruising or discoloration of the skin over the treated area.*
- b. *Blistering, scarring. Activation of cold sores, infection or permanent discoloration, which may occur in rare cases. Please inform us if you have ever had a problem with cold sores.*
- c. *Folliculitis , which is an infection of the hair follicle. Which may take several days to resolve.*
- d. *Hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) , which rarely may take several months to fully resolve.*
- e. *Crusting or blistering of the area is exposed to laser , which is rare and which may take several days to heal.*

f. *As with all LHR procedures, some re-growth of hair may occur after treatment sessions are completed.*

*6. **<u>POST PROCEDURE INSTRUCTIONS:</u>** It is important that you comply with all post procedure instructions in addition, it is important that you limit sun exposure after the LHR procedure and use protective sunscreen lotion. Please call your doctor promptly if complications develop after the procedure . Laser -treated areas should not be exposed to sun or tanning beds . Not adhering to the post treatment skin care instructions may increase the risk of complications.*

BY SIGNING THIS INFORMED CONSENT , YOU UNDERSTAND AND AGREE AS FOLLOWS: *(CHECK ALL THAT APPLY):*

- ☐ *The information contained in this Informed Consent was explained to me using terms I could understand, and all my questions and concerns have been answered . After reviewing all the information provided to me about cosmetic procedures and reviewing my health status, I believe I am a good candidate for LHR.*
- ☐ *I understand that LHR is an elective procedure and hereby freely accept all possible risks, complications and side effects that may result from this procedure.*
- ☐ *I acknowledge that the LHR procedure will be performed by an employee of medical cosmetic enhancements, who is properly trained and certified in its usage.*
- ☐ *I agree to return for any recommended follow up visits and follow post-procedure instructions .*
- ☐ *I understand that no guarantees have been made to me regarding the outcome of the LHR procedure .*
- ☐ *This consent form is valid for all future hair removal treatments performed , and if I will alert the staff if there are any future changes to my medical history , or if I become pregnant.*

DATE :_____________

PATIENTS NAME :_______________________________________

PATIENTS SIGNATURE :___________________________________

STAFF REPRESENTATIVES SIGNATURE: ______________________________

HIPAA Privacy Authorization Form **Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.Parts 160 and 164)**

Dear Patient:

This is to inform you that a copy of the HIPAA is available upon request and a copy of the HIPAA is also displayed at our office. Please read over and sign below, verifying that you are aware of your HIPAA rights as outlined above and that you grant permission to acknowledge you as a client for referral and appointment scheduling purposes only.

PHOTOGRAPHS I agree to have my photographs taken for proof of medical documentation.

_____ I **DO** authorize use of my image for purposes other than medical documentation

_____ I **DO NOT** authorize use of my image for purposes other than medical documentation

____ ___________________________

Patient Name - PRINTED Date

____ ___________________________

Patient - SIGNATURE Date

____ ___________________________

Representative Date