Intake Form

DATE:_____
NAME:_____
DOB:_____

ADDRESS:_____
CITY/STATE/ZIP CODE: _____
EMAIL: _____
CELL PHONE: (_____) _____-_____ OCCUPATION:_____
HOW DID YOU HEAR ABOUT US? (Include Referall's Name): _____

ARE YOU INTERESTED IN:

- ❑ **Body Sculpting/fat reduction/Weight loss**
- ❑ **Sun damage**
- ❑ **Redness/Rosacea**
- ❑ **Hair Removal/Restoration**
- ❑ **Personal wellness treatments**
- ❑ **Stretch mark/Scar Reduction**
- ❑ **Anti-Aging/ Resurfacing**
- ❑ **Skin care/ at home care**
- ❑ **Injectables/ Fillers**
- ❑ **IV Vitamin Infusion**
- ❑ **Acne**

Have you ever had any of these procedures before? If yes, please list:
_____
_____

MEDICAL AND LIFESTYLE HISTORY:
Have you ever had any of the following conditions?:

- ❑ Heart Disease
- ❑ Kidney Disease
- ❑ Anemia
- ❑ Diabetes
- ❑ Cold sores/Fever Blister
- ❑ High Blood Pressure
- ❑ Bleeding Disorders
- ❑ Keloid Scarring
- ❑ Metal Implants
- ❑ Eating Disorder
- ❑ Dermatitis
- ❑ Seizures
- ❑ Liver Disease
- ❑ Cancer
- ❑ HIV Hepatitis

If yes, please explain: _____
_____

Are you/Do you:

SMOKE	● YES	NO	How Often? _____
DRINK	● YES	NO	How Often? _____
EXERCISE	● YES	NO	How Often? _____
USE TANNING BOOTHS	● YES	NO	How Often? _____
PREGNANT/NURSING	● YES	NO	

Do you use any of the following topical/oral medications?

❑ Accutane	❑ Adapalene/Differin	❑ Hydroquinone
❑ Retin-A/Retinol	❑ Topical Antibiotics	❑ Renova/Refissa/Tretinoin
❑ Hydroquinone	❑ Oral Antibiotics	❑ Tazarac/Tazarotene/Avage

Please list all Prescription Medications and Supplements: _____

_____

_____

Are you allergic to:

❑ LATEX
❑ IODINE

Please list all food allergies: _____

_____

PAST SURGICAL HISTORY:

_____

_____

_____

APPOINTMENT POLICY AND CHECK IN

Please arrive 30 minutes prior to your appointment to allow time to sign consent forms, take before and after pictures, or apply numbing cream (when necessary). If you are late, we will try our best to accommodate you, but we cannot guarantee your full service time.

If you need to reschedule or cancel your appointment, please give us 24-hour notice when possible. If you fail to let us know you cannot make your appointment (No Show), your account will be charged a $25 inconvenience fee.

I, _____, acknowledge and agree to these terms.

_____ _____

Signature of Client/Guardia Date

PHOTO CONSENT

I,_____, authorize Foyé MD and Spa, LLC. and its staff to take before, during and after photographs or videos of procedures performed on me. I understand that these will be used to determine efficacy and for quality control measures.

May we use your photographs in social media posts/marketing materials/etc? We will not include your name or any identifying features without further consent.

- YES, I consent to my photographs to be used.
- NO, I do not consent to my photographs to be used

_____ _____

Signature of Client/Guardian Date

REFUND POLICY

All purchases for services are final. Retail items may be exchanged for item of equal value at is original price if unopened and within 30 days of original receipt.

All pre ordered product for clients must be paid for in full on date of agreement for purchase. Each item purchased is specifically bought for the client and thus is a final sale for the product and service.

Signature below indicates agreement with refund policy.

_____ _____

Signature of Client/Guardian Date

Authorization and Release for Interviews and/or Images for Media* and Promotional Activities

1. I hereby authorize (name) and **Foye MD and Spa** to use and/or disclose the name, images and/or health or personal information of:

LAST NAME_____ **FIRST NAME**_____ **M.I.**___

DATE OF BIRTH_____**TELEPHONE NUMBER**_____

RELATIONSHIP TO Foye MD and Spa *(Circle all)* **Patient Employee Student Volunteer Other** _____

2. The following information can be used and/or disclosed: (check all that apply)

- ☐ Any information obtained during an interview with the above-named person, including, but not limited to, health information, personal information and/or testimonial (e.g., patient, student, donor, employee)
- ☐ Photographs or other images
- ☐ Medical information about the patient's condition if requested by media; this may include copies of the medical record, conversations with attending physician(s) and/or copies of bills and finances

Other:

3. I authorize FOYE MD AND SPA to disclose the information (as described above) to the public through any form of media (e.g., university publication, newspaper, TV, magazine, Internet, film, etc.), or as otherwise specified below.

4. I understand the purpose(s) of the requested use or disclosure is (are) as follows: (check all that apply)

- ☐ General publicity or marketing, including fundraising, recruitment and advertising materials
- ☐ FOYE MD AND SPA publications and/or digital outlets (e.g. www.foyemdandspa.com, social media)
- ☐ News related to TV, radio or print media inquiries

Other:

5. I understand this authorization is voluntary and I may refuse to sign. If I am a patient, FOYE MD AND SPA may not withhold treatment based on the completion of this authorization.

6. I understand that I may revoke this authorization at any time by notifying in writing and expressing to FOYE MD AND SPA at 3800 North Shepherd Drive, Houston, TX 77018 of my intent to revoke this authorization. I understand that such a revocation will have no effect on information already used or disclosed by FOYE MD AND SPA prior to FOYE MD AND SPA's receipt of my written notice of revocation.

7. Unless otherwise revoked, I understand that this authorization will expire when the information is no longer useful to the education, patient care or research missions of FOYE MD AND SPA, at which time the information will be destroyed.

8. I understand that the information disclosed pursuant to this authorization may be re-disclosed by the end user (e.g., media outlet) and no longer protected by federal or Texas privacy laws.

9. I release FOYE MD AND SPA and its Regents, officers, agents and employees from any and all liability connected with use or disclosure of this information in the media application(s) listed above.

10. I give my consent in the interest of public information, for the furtherance of education, patient care and the research goals of this institution, or for other lawful purposes.

11. I waive all rights, interest or claims for payment in connection with any exhibition or release of this information in the media application(s) listed above.

12. If I am being treated for drug or alcohol abuse, a mental health or psychiatric disorder, or acquired immunodeficiency syndrome or human immunodeficiency virus, I understand that information regarding my condition may be used.

13. I understand that FOYE MD AND SPA may choose to copyright images or printed matter for its own benefit and may decide to protect unauthorized users from further using or reproducing the images or printed matter.

INDIVIDUAL SIGNATURE OR AUTHORIZED LEGAL REPRESENTATIVE_____

DATE_____

PRINTED NAME OF LEGAL REPRESENTATIVE/GUARDIAN_____

LEGAL REPRESENTATIVE'S/GUARDIAN'S RELATIONSHIP TO INDIVIDUAL_____

***Note:** *Contact Media Relations office at 281-766-8916 for assistance with media inquiries*

****Responsible for*

(1)*ensuring form is kept on file according to state records-retention guidelines and*

(2)*ensuring a copy of form is provided to individual or guardian named above*

CONSENT FOR LASER/LIGHT-BASED and AESTHETIC TREATMENT

I authorize _____ to perform laser/pulsed light cosmetic skin treatments on me, including, but not limited to, the treatment of pigmented lesions (for example, sun spots, age spots, and other skin discolorations), vascular lesions (for example, red spots, and small spider veins, but not varicose veins), wrinkles, (rhytides), furrows, fine lines, textural irregularities, non ablative skin resurfacing, soft tissue coagulation, ablative skin resurfacing, and reducing or eliminating hair, IV Infusion and supervised weight loss. I understand that the procedure is purely elective, that the results may vary with each individual, and multiple treatments may be necessary. I understand that: All personnel in the treatment room, including me, must wear protective eyewear to prevent eye damage from this light energy. The sensation of light is sometimes uncomfortable and may feel like a moderate to severe pinprick or flash of heat. Anesthesia or sedation (calming medication) may be advisable for laser skin resurfacing treatments. If the practitioner or physician elects to use an anesthetic to reduce discomfort during any light-based treatment, all options and risks associated with the anesthetic will be discussed with me. The treated area may be red and swollen for two to twenty-four (2–24) hours or longer. Cooling the area after the treatment (for example, ice packs, topical gels) may help reduce discomfort and swelling. Common side effects include temporary redness (erythema) or mild "sunburn"-like effect that may last a few hours to 3-4 days or longer. Other potential side effects include, but are not limited to, crusting, irritation, itching, pain, burns, scabbing, swelling (edema), broken capillaries, bronzing, and acne or herpetic breakouts. There also is a risk of resulting unsatisfactory appearance and failure to achieve the desired result. Pigment changes, including hypo pigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin), lasting one to six (1-6) months or longer or permanently may occur. Freckles may temporarily or permanently disappear in treated areas. Serious complications are rare but possible, such as, scarring, blood clots, skin loss, hematomas (collection of blood under the skin), and allergic reaction to medications or materials used during the procedure. I understand and accept that with skin resurfacing treatments, there may be an increased length of social downtime associated with the level of treatment. There also is a chance of additional side effects like blanching and significant redness. With ablative laser treatments, there are additional risks of discomfort, focal areas of bleeding, bruising, poor healing, serous discharge, and infections. Serious but rare complications may include scarring, abscess, skin necrosis (dead skin), and injury to other internal structures including nerves, blood vessels, or muscles. An occlusive ointment may be used to cover the treated skin and keep it moist to avoid the skin drying out and being crusty or desquamated. Occlusion may exacerbate acne breakouts under the ointment. There is no guarantee that the expected or anticipated results will be achieved.

Sun, tanning bed, or tanning lamp exposure, the use of self-tanning creams, and not adhering to the post-treatment instructions provided to me may increase my chance of complications. I must avoid the sun, tanning beds, and sunless tanning lotions and use sunblock (SPF 45 recommended) after treatment. There is a possibility of coincidental hair removal when treating pigmented or vascular lesions in hair-bearing areas. There is a risk that the hair regrowth may be changed, such as little or no regrowth or more regrowth than before. I should call my provider as soon as possible if I have any concerns about side effects or complications after treatment. I hereby consent to the administration of any anesthesia or sedation considered necessary or advisable for my procedure(s). I understand that all forms of anesthesia and sedation involve risk and the possibility of complications, injury, and in rare instances death. Not providing my medical history before proceeding with a light-based treatment could impact treatment results and cause complications. I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly without my permission. Before and after-treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction. I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered. I freely consent to the proposed treatment today as well as for future treatments as needed.

Signature: _____ Date _____
Print name: _____
Witness signature: _____ Date: _____
Print name: _____

Arbitration Agreement

Article 1: Agreement to arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All claims must be arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a backup for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damage exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief or punitive damages.

Article 3: Procedures and applicable law" A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter and located within the Harris County. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with the other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in the arbitration of any person or entity that would otherwise be an additional person or entity shall be stayed pending arbitration.

The parties agree that the provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgement for future damages conformed to periodic payments, shall apply to the dispute within the Arbitration Agreement. The parties further agree that the commercial Arbitration rules of the American Association shall govern any arbitration conducted pursuant to the Arbitration Agreement.

Article 4 : General provisions: All claims based upon the same incident, transaction, or relate circumstance shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6 : Retroactive effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here___. Effective as the date of the first professional service.

If any provisions of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. see article 1 of this contract.

Patient Signature_____Date_____

Office Signature_____Date_____

FINANCIAL AGREEMENT

Foye MD and Spa relies on open communication with our patients regarding our financial policy and will assist in providing the best service to you.

Please select from the following payment choices:

_____**Self-Pay –** I agree to pay my balance in full at the time of service.

_____**Private Insurance –** Foye MD and Spa will bill your primary insurance.

INSURANCE BILLING

As an extended service to you, a claim will be filed with your primary insurance carrier for every applicable NON COSMETIC health related service you receive at Foye MD and Spa.

Although we are happy to assist you in filing a claim with your insurance carrier, it is important for you to remember that you are the insured. You, or your employer, have selected the carrier and your coverage. AMH strongly encourages you to question your insurance carrier regarding delays in payment and/or the amounts paid. We will make every effort to follow up on the claims we have filed on your behalf, but we cannot accept the responsibility for misquoted benefits, insufficient coverage or slow payment.

In assisting you to file your insurance claims, we will need complete and accurate information. If for any reason, your insurance coverage should change, please inform us immediately so that Foye MD and Spa may make the appropriate changes to your account.

PAYMENTS

Please be aware that Foye MD and Spa requires payment for all co-pays, deductibles, coinsurances, and supplies that your insurance will not cover at the time of service, unless other arrangements have been made with our facility.

As we receive payments or notifications from your insurance company, we will present you with a statement. Payment of this/any outstanding balance will be due at the time of service. Completion and signature of our Credit Card on File Authorization will allow us to charge your credit card for allowed amounts due from you.

In the event that your account becomes delinquent and is therefore in default of payment, you will be responsible for the principal amount owed and all reasonable costs associated with the collection of this debt, including:
collection service fees, attorney's fees, court costs, and additional legal expenses associated with the recovery of the debt.

Please contact us at any time with any questions regarding your account and/or balance

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PatientSignature Date