Heron Med Spa services

Client Name:_____Date: _____

Street Address:_____

City:_____ State:_____Zip Code: _____

Date of Birth:___/___/___ Gender: Female____ Male____

Telephone: Home:_____ Work: _____

Mobile:_____ Email: _____

1. How did you hear about us? _____

	Oily Skin		Cold Sores		Skin Cancer (Self)
	Dry Skin		Chronic Skin Conditions		Skin Cancer in Family
	Combination Skin				
	Chronic Acne		Chemical Peel		Laser Skin Resurfacing
	Keloid Or Hypertrophic Scar		Recent Electrolysis or Threading (4-6 Wks)		Accutane Use for Acne When?
	Recent Sunburn or Tan (Tanning Bed or Self-Applied)		Recent Waxing or Plucking		Recent Injection of Botox, Collagen, or Other Dermal Fillers

2. When exposed to sun without sun block or sunscreen do you usually:

___Always burn, never tan ___Burn minimally, tan easily ___Tan after initial burn

___Burn easily, tan poorly ___Rarely burn, tan darkly ___Never burn, always

3. Do you use sunscreen regularly? _____

4. Do you use artificial or "sunless" tanning products? _____

5. Check any of the following areas of current interest/concern.

	Sun Damage		Acne		Hair Removal
	Skin Tightening		Rosacea		Cellulite
	Wrinkles		Skin Discoloration		Anti-Aging
	Age Spots, Freckles		Skin Texture		Dry skin
	Creating a healthy on-going skin care regime		Restorative Skin Care		Oily skin

Primary Skin Concern: _____

6. Do you take daily vitamins and supplements? _____

Medical History

1. Please check all of the following that apply to you.

_____Heart disease	_____Diabetes	_____Auto-immune disease
_____Hypertension	_____Hepatitis	_____Use tobacco products
_____Easy bleeding/bruising	_____Endocrine/Hormonal disorder	_____History of radiation therapy in application area
_____Wear contact lenses	_____Allergies to salcylates	_____Current or recent pregnancy
_____Delayed or abnormal wound healing, sunburned or excessively sensitive skin (within application area)	_____Active cold sores, herpes simplex or warts in area to be treated	_____

2. List any current medical problems: _____

_____

_____

3. List medications you currently take: _____

_____

_____

4. List any medication allergies: _____

_____

Are you allergic to latex?_____Are you allergic to any metals? _____

5. History of Past Illnesses and Surgeries: _____

_____

_____

6. Emergency contact:_____ Relationship: _____

Contact Information: _____

I have been given an opportunity to read and review the "Notice of Privacy Practices."_____(Initials)

Client Signature:_____ Date: _____

Parent or Guardian (if client is under 18 years of age):

Signature:_____ Date: _____

Heron Med Spa

Marketing Authorization and Use of Photographs

According to federal law we must ask for your permission to send to you via email or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e., office promotions that include special discounts). Our office **DOES NOT SELL** our patients names.

This authorization is effective until revoked in writing.

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying DWLC in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by DWL&HSLC in reliance on this authorization before DWL&HSLC receives my request for revocation or modification. I must sign my written request and send it to:

Privacy Contact
Doctor's Weight Loss & Heron SmartLipo Centers, 321 South Patrick Street, Alexandria, VA 22314

I **DO** _____ I **DO NOT** _____

Authorize Doctor's Weight Loss Centers, Inc (DWLC) to use and disclose my Protected Health Information (PHI) to mail to me any information regarding the products, services or promotions the practice offers.

I **DO** _____ I **DO NOT** _____

Authorize Doctor's Weight Loss Centers, Inc. (DWLC) services or promotions the practice offers.

_____ _____

Patient Signature Date

_____

Email Address (Please Print)

Doctor's Weight Loss Centers, Inc.

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. Please review it carefully.

Doctor's Weight Loss Centers, Inc,, is committed to **protecting your privacy** and understands the importance of safeguarding your personal health information. We are required by federal law to maintain the privacy of health information that identifies you or that could be used to identify you (known as "**Protected Health Information**"). We also are required to provide you with this Notice, which explains our legal duties and privacy practices with respect to **Protected Health Information** that we collect and maintain. This Notice describes your rights under federal law and state law, where applicable, relating to your Protected Health Information. DWLC is required by federal law to abide by this Notice. However, we reserve the right to change the privacy practices outlined in this Notice and make the new practices effective for all **Protected Health Information** that we maintain. Should we make such a change, we will display the revised Notice in our office and make it available to you upon request.

Uses and Disclosures of Protected Health Information
Your **Protected Health Information** may be used and disclosed by our physicians, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your **Protected Health Information** may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your Protected Health Information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your **Protected Health Information** to provide, coordinate, or manage your health care and any related services. For example, we would disclose your **Protected Health Information** to other physicians or health care providers (e.g., a specialist or laboratory) who may be treating you, and 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 Information** will be used, as needed, to obtain payment for your services. Elective procedures are not covered by health insurance. Payment must be made by credit card, cash, certified check or financing instruments.

Healthcare Operations: Your **Protected Health Information** can be used and disclosed to allow us to conduct health care operations, which generally are the administrative activities that we undertake in order to operate our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

For example, we may disclose your **Protected Health Information** to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the front desk, call you by name in the waiting room, to contact you to remind you of your appointment or to call you following surgery.

We will share your **Protected Health Information** with third party "business associates" that perform various activities (e.g., anesthesia, billing, collection agency, and/or transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your **Protected Health Information**, we will have a written contract that contains terms that will protect the privacy of your Protected Health Information.
Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object Required By the Secretary of Health and Human Services: We may be required to disclose your **Protected Health Information** to the Secretary of Health and Human Services to investigate or determine our compliance with the federal privacy law.

Required By Law: We may use or disclose your **Protected Health Information** to the extent that the use or disclosure is otherwise required by state or federal law.

Public Health: We may disclose your **Protected Health Information** for public health activities and purposes to a public health authority or other government agency that is permitted by law to collect or receive this information (e.g., the Food and Drug Administration).

Communicable Diseases: We may disclose your **Protected Health Information**, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose **Protected Health Information** to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: If you have been a victim of abuse, neglect, or domestic violence, we may disclose your **Protected Health Information** to the government agency authorized to receive such information.

Food and Drug Administration: We may disclose your **Protected Health Information** to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose **Protected Health Information** in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal in certain conditions in response to a subpoena, discovery request or other lawful process not accompanied by a court order.

Law Enforcement We may also disclose **Protected Health Information**, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose **Protected Health Information** to a coroner, medical examiner and funeral director if it is needed to carry out their duties.

Research: We may disclose your **Protected Health Information** to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your **Protected Health Information**, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual.

_____**Patient Initials**

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose **Protected Health Information** of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your **Protected Health Information** may be disclosed to comply with workers' compensation laws and other similar programs.

Inmates: We may use or disclose your **Protected Health Information** if you are an inmate of a correctional facility and your physician created or received your **Protected Health Information** in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your **Protected Health Information**, not described above, will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the authorization.

We may use or disclose your **Protected Health Information**, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your Protected Health Information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer and/or thank you cards for referring another patient. We may also send you information about products or services that we believe may be beneficial to you as long as we have obtained the proper authorization from you. You may contact our Privacy Contact to request that these materials not be sent to you.

Your Rights. As a patient, you have certain rights regarding your **Protected Health Information**. We may ask that you submit a written request to exercise your patient rights. These rights include: **You have the right** to inspect and copy your **Protected Health Information**. If you would like to see or copy your **Protected Health Information**, we are required to provide you access to your **Protected Health Information** for inspection and copying within 30 days after receipt of your request (60-days if the information is stored off-site). We may charge you a reasonable fee to cover duplicating costs. In addition, there may be situations where we may decide to deny your request for access. For example, we may deny your request if we believe the disclosure will endanger your life or health or that of another person. Depending on the circumstances of the denial, you may have a right to have this decision reviewed.

You have the right to request a restriction of your **Protected Health Information**. This means you may ask us not to use or disclose any part of your **Protected Health Information** for the purposes of treatment, payment or healthcare operations. You may also request that any part of your **Protected Health Information** not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction. If your physician does agree, we will abide by your restriction unless we need to use your **Protected Health Information** to provide emergency treatment. In addition, we may elect to terminate the restriction at any time.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may request that we send written communications to an alternative address. We will attempt to accommodate reasonable requests and will not request an explanation from you as to the basis for your request.

You have the right to have your physician amend your protected health information. This means you may request an amendment of **Protected Health Information** in our records for as long as we maintain this information. We will respond to your request within 60 days (with up to a 30-day extension, if needed). We may deny your request if, for example, we determine that your **Protected Health Information** is accurate rate and complete. If we deny your request, we will send you a written explanation and allow you to submit a written statement of disagreement.

You have the right to receive an accounting of certain disclosures we have made, of your **Protected Health Information**. An accounting is a record of the disclosures that have been made of **Protected Health Information**. This right generally applies to non-routine disclosures, i.e., for purposes other than treatment, payment, or health care operations, as described in this Notice, made in the 6-year period prior to your request (although you are free to request an accounting for a shorter period). We are required to provide the accounting within 60 days (with up to a 30-day extension, if needed) and to provide one accounting free of charge in any 12-month period. (For more frequent requests, a reasonable fee may be charge). You have the right to receive specific information regarding these disclosures that occurred after May 24, 2008.

Other Permitted and Required Uses and Disclosures That May Be Made With **Your Consent, Authorization or Opportunity to Object**

We may use and disclose your **Protected Health Information** in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your Protected Health Information.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your **Protected Health Information** that directly relates to that person's involvement in your health care (i.e. after surgery at our office or at the hospital). If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose **Protected Health Information** to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your Protected Health Information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your **Protected Health Information** in an emergency treatment situation.

Communication Barriers: We may use and disclose your **Protected Health Information** if your physician attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

This Notice was first published and became effective on May 24, 2008.

_____ _____

Signature of Patient or Legal guardian **Date**