

PHYSICIANS MED SPA PATIENT INFORMATION/INTAKE FORM

First Name: _____ Cell Phone: _____
Last Name: _____ Home Phone: _____
Address: _____ Occupation: _____
City: _____ Email: _____
State: _____ Zip Code: _____ How you heard of us: _____
Date of Birth: ____/____/____ - if referred, name: _____

Interests and Concerns

Please check all the boxes of areas of interest and/or any concerns you have

- | | | |
|--|---|--|
| <input type="checkbox"/> Chemical Peels / Dermabrasion | <input type="checkbox"/> Spider Veins / Vascular Lesions | <input type="checkbox"/> Pigment / Dark Spots |
| <input type="checkbox"/> Body Contouring | <input type="checkbox"/> Large Pores and/or Blackheads | <input type="checkbox"/> Hyperhidrosis (Sweating) |
| <input type="checkbox"/> Tattoo Removal | <input type="checkbox"/> Thick/Discolored Nails (Fungus) | <input type="checkbox"/> Weight Loss/Management |
| <input type="checkbox"/> Spa Facial / HydraFacial | <input type="checkbox"/> Vaginal Dryness and/or Pain | <input type="checkbox"/> Acne / Pimples |
| <input type="checkbox"/> Skin Care | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Loose or Sagging Skin |
| <input type="checkbox"/> Hair Restoration (Alopecia) | <input type="checkbox"/> Facial Shape / Structure / Balance | <input type="checkbox"/> Nutritional Counseling |
| <input type="checkbox"/> Hair Removal | <input type="checkbox"/> Cellulite / Fat Deposits | <input type="checkbox"/> Non-Surgical Facelift |
| <input type="checkbox"/> Fine Lines and/or Wrinkles | <input type="checkbox"/> Personal Fitness Training | <input type="checkbox"/> Eyelash Lift & Color |
| <input type="checkbox"/> Scars and/or Stretch Marks | <input type="checkbox"/> Exosome Therapies | <input type="checkbox"/> Eyebrow Wax & Color |
| <input type="checkbox"/> General Wellness | <input type="checkbox"/> Hormone Balancing | <input type="checkbox"/> Aquafirm _{EXS} Therapy |
| <input type="checkbox"/> Lip Filler | <input type="checkbox"/> Eye Area Concerns | <input type="checkbox"/> Spa Facials |
| <input type="checkbox"/> Loss of Libido | <input type="checkbox"/> Skin Tags / Benign Lesions | |

Medical and Aesthetic History

Are you under the care of a medical professional for any condition? ___ Yes ___ No *If yes, what for?*

Please list previous surgeries/significant injuries:

Please list all present medications, including antibiotics:

Do you have any allergies or sensitivities (Latex, Medications, Lidocaine, Foods, Aloe, Aspirin, Sulfur):

What other aesthetic procedures/treatments have you had? *Please include approximate timing.*

Do you smoke cigarettes? _____ If yes, when did you start? _____ If yes, how often? _____

Do you have any tattoos, permanent makeup, or body piercings in the area to be treated?

PHYSICIANS MED SPA POLICIES & PROCEDURES

Our Mission

We always provide excellent care, and we strive to improve ourselves and our Med Spa every single day. We ensure everyone's safety as well as their comfort, and make certain we have the best possible products & devices. We must keep business flowing to pay salaries and to keep the lights on & doors open. The Spa exists to provide individualized medical aesthetic care, so our overarching top priority is ALWAYS making sure you feel both improved and happy in your RELATIONSHIP with us.

Continued/Ongoing Consent

We generally do not have patients sign forms every time they are treated. I understand that my Med Spa care generally consists of a series of treatments to achieve maximum benefit, and that my written and verbal consent shall apply forevermore to all services rendered to me by the Med Spa, including both ongoing and intermittent treatments.

Warranty

Although excellent results are anticipated and expected, there can be no guarantee or warranty, expressed or implied, by anyone, at any time, as to any results. Every person's response is different and cannot be fully predicted and results of your treatment(s) may not be immediately apparent, so additional treatments may be required beyond those initially planned. The only way to know if additional treatment may be needed is reassessment after each treatment. These could result in additional charges, for which you may be responsible. We do not have any dermatologists on staff and therefore cannot provide dermatologic diagnoses or prognoses or treatment. Our staff can assess and manage ONLY the cosmetic and aesthetic components of skin issues. If you have any medical or surgical concerns whatsoever about your skin, you must see a dermatologist for their assessment. We cannot provide guarantees of results, but we are proud to be the co-pilots on your lifelong aesthetics journey. We want you to feel empowered while we come along on your ride, so please help us chart the course with open communication and be sure to let us know how we're doing!

Payment

Payment is required up front, prior to treatments or consultations, for any and all products and services. Accepted forms of payment include cash, Vagaro Pay Later, Cherry, CareCredit, debit card, your Spa Member "piggy bank", or credit card. Checks are not an accepted form of payment. Discounts and promotions cannot be bundled or combined.

Photographs

Pictures will be obtained during your initial consultation and at all future appointments for objective visual documentation of your condition before and after treatment. You are being treated at a medical facility, and your photos are part of your legal medical record (confidential Protected Health Information), which you will be able to access at any time online through your Vagaro account. Pictures will help us (and you) record and track your progress and may also be used for promotional and/or scientific purposes, in publications and/or presentations. Please rest assured that your identity will ALWAYS be protected.

Refunds

If any purchased treatment is no longer wanted, we will happily issue you a credit that you may transfer to anything else we offer. Unused balances on packages you do not wish to complete can also be used as a credit for other services or products, or they can even be transferred to another individual! Sealed unopened products are eligible for a full refund within 7 days of purchase. There are no refunds for services rendered, prescription medications, nor for any used or opened products. All services and products that are purchased on promotion or at a discount are final sales.

Appointments

We understand that there are situations that arise that may prevent you from arriving on time or coming at all. However, if you do not call to cancel an appointment, you will have prevented another patient from being seen during the time we blocked off for you. Keeping your appointment is very important to us, so we will provide a reminder.

Missed appointments: Any time you do not arrive before your scheduled appointment, you will be subject to a fee: currently \$100 for physician appointments, \$50 for others. These fees are subject to change.

Notification time: Appointments MUST be canceled or rescheduled more than 24 hours before the appointment time. If we are not informed at least 24 hours in advance that you will not attend, you will be charged for a missed appointment. Acceptable methods of notification are either text messages sent to 203-491-0070 or calling 203-877-6568 to speak to a staff member or leave a message.

PLACE AN "X" TO DESCRIBE YOUR LEVEL OF THESE SYMPTOMS

	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1. Hot flashes, sweating (independent of strain)	<input type="checkbox"/>				
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	<input type="checkbox"/>				
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	<input type="checkbox"/>				
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	<input type="checkbox"/>				
5. Irritability (feeling nervous, inner tension, feeling aggressive)	<input type="checkbox"/>				
6. Anxiety (inner restlessness, feeling panicky)	<input type="checkbox"/>				
7. Increased need for sleep, naps	<input type="checkbox"/>				
8. Anxiety (inner restlessness, feeling panicky)	<input type="checkbox"/>				
9. Physical and mental exhaustion (general decrease in performance, impaired memory/forgetfulness, decrease in concentration, lack of interest)	<input type="checkbox"/>				
10. Decreased libido (decreased sexual desire, in sexual activity and satisfaction)	<input type="checkbox"/>				
11. Decrease in muscle strength (feeling weak)	<input type="checkbox"/>				
12. Decline in your feeling of general well-being (state of health, subjective feeling)	<input type="checkbox"/>				
13. Feeling you have passed your peak (you felt more like yourself when younger)	<input type="checkbox"/>				
14. Joint and/or muscular pain (back pain, body aches)	<input type="checkbox"/>				
15. Decline in your feeling of general well-being (state of health, subjective feeling)	<input type="checkbox"/>				

Do you have cold hands and feet? Yes No

Do you have daily bowel movements? Yes No

Do you have gas, bloating or abdominal pain after eating? Yes No

Height: _____ Weight: _____

Select your WEEKLY Activity Level that accelerates heart rate / creates breathlessness

0-1 day per week (Low) 2-3 days per week (Average) More than 3 days per week (High)

List any prior hormone therapy:

Please share any additional comments about any symptoms you would like us to address:

MEN ONLY – Place an “X”

	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
16m. Decrease in ability/frequency to perform sexually	<input type="checkbox"/>				
17m. Decrease in beard growth	<input type="checkbox"/>				
18m. Decrease in number of morning erections	<input type="checkbox"/>				

Recent PSA: _____ Recent Digital Rectal Exam (Date): _____ Normal / Abnormal
 History of prostate problems or biopsy? If so, please provide details: _____

WOMEN ONLY – Place an “X”

	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
16w. Urinary problems (incontinence, urinary difficulty)	<input type="checkbox"/>				
17w. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	<input type="checkbox"/>				

Last mammogram: _____ PCOS: Yes No Hormonal Disorders: Yes No
 Birth Control: Yes No - *if yes, how & when diagnosed?* _____ - *if yes, please list:* _____
 - *if yes, name method(s):* _____
 In Menopause: Yes No Are you pregnant: Yes No Regular Periods: Yes No
 If yes, due date: _____ Hysterectomy: Yes No

Have you ever had any of the following?

- Heart or Vascular Condition
- Cancer Treatment
- Diabetes Mellitus 1 / 2 (*circle one*)
- Coagulation / Blood Disorder
- Herpes (including cold sores)
- Pacemaker / Implants
- Hepatitis: (Type ____)
- HIV/AIDS / Immunosuppression
- Keloid (heavy scarring)
- High or Low Blood Pressure
- Psoriasis
- Rosacea
- Seizures or Passing Out
- Vitiligo (Hypopigmentation)
- Eczema

Skin Questionnaire

- Have you used Accutane within the last **6 months**? Yes No
- Have you used hydroquinone or retinol/retinoic acid within the last **2 weeks**? Yes No
- Have you used any oral or topical antibiotics in the last **2 weeks**? Yes No
- Have you had any injectables in the treatment area within the last **4 weeks** (fillers, Botox, etc.)? Yes No
- Have you had a chemical or acid peel on the treatment area within the last **6 weeks**? Yes No
- Are you currently using exfoliative therapy (alpha hydroxy or glycolic acid or mandelic acids)? Yes No

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (H.I.P.A.A.)

NOTICE OF OUR PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health/personal information (PHI) to carry out treatment, payment or business operations (IPO) 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 that relates to your past, present or future physical or mental health or condition and related health care services.

Confidentiality: No information regarding services performed shall be released without my express consent unless you authorize that copies of your records may be sent to another location if you seek additional treatment at that location. In addition to authorized clinic personnel, the Med Spa's Medical Director and consulting physicians shall have full access to your treatment records. Appropriate medical review may be conducted to further the safety and efficacy of your care. Physicians Laser Center and Med Spa, LLC (dba Physicians Med Spa), may also provide limited patient information to various third-party vendors to provide database development and maintenance services, referral services or marketing research services. Photographs may be taken to document treatment results. The Med Spa will maintain file copies of all records for a minimum of three years. Your 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 health care services to you to support clinical and 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 health care and any related services. This includes the coordination or management of your health care 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 another physician. Your protected health/personal information may be provided to a physician to whom you have been referred to in order 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 your authorization. These situations include: as required by law; public health issues is 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 Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

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

Complaints: We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health/personal information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main business phone number. You may complain to us or to the United States 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 Medical Director of your complaint. We will not retaliate against you for filing a complaint.

Following is a statement of your rights with respect to your protected health/personal information

You have the right to inspect and copy your protected health/personal information. Under federal law, however, you may not inspect or copy the following record information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected health/personal information.

You have the right to require a restriction of your protected health/personal information. This means you may ask us not to use or disclose any part of your protected health/personal information for the purposes of treatment or healthcare operations. You may also request that any part of your protected health/personal information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If our medical director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your protected health/personal information will not be restricted. You then have the right to use another service provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively, i.e., electronically.

You may have the right to amend your protected health/personal information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health/personal information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.

CONSENT, RELEASE, AND INDEMNITY AGREEMENT

1. Purpose: It is herein understood that any financial or civil disagreement or dispute as to our care - that is, as to whether any medical or aesthetic services rendered under this contract failed to meet the standard of care or were unauthorized or improperly, negligently, or incompetently delivered - will be determined by submission to arbitration and not by litigation, lawsuit, or any court process. All parties to this contract, by voluntarily entering it, are giving up their right to have any civil concern or dispute whatsoever decided in a court of law by a judge and/or jury and are instead agreeing to the use of binding arbitration, except as applicable law provides for judicial review of arbitration proceedings.

2. All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies, whether in finance, tort, contract, or otherwise, and shall bind all parties whose claims may rise out of or in any way relate to treatment or services interactions with or by Physicians Laser Center and Med Spa, LLC (dba "Laser Center of Milford" and/or "Physicians Med Spa"), its officers, employees, and/or independent contractors.

3. Procedures and Applicable Law: Any 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 of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party of such party's own benefit.

The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and the joinder in this arbitration of any person or entity, which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provision of Connecticut law applicable to health care providers shall apply to disputes with this arbitration agreement, including, but not limited to, Connecticut Code of Civil Procedure and Connecticut Civil Code. Any party may bring before the arbitrators a motion for summary judgment of summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Connecticut Code of Civil Procedure; however, depositions may be taken without prior approval of the neutral arbitrator.

4. Severability: If any provision of this arbitration agreement is held invalid or unenforceable, all other provisions shall remain in full force and shall not be affected by the invalidity of any other provisions.

PLEASE ASK US ANY QUESTIONS YOU HAVE BEFORE SIGNING THIS SEVEN PAGE FORM. IT IS VERY IMPORTANT THAT YOU UNDERSTAND IT IN ITS ENTIRETY AND IT IS OUR PLEASURE TO PROVIDE EXPLANATIONS AND CLARIFICATIONS.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE AND CERTIFY THAT: I HAVE READ AND UNDERSTAND THIS ENTIRE SEVEN PAGE AGREEMENT; THAT I VOLUNTARILY AGREE TO HAVE ANY AND ALL ISSUES RELATED TO PHYSICIANS LASER CENTER AND MED SPA, LLC, DECIDED BY NEUTRAL ARBITRATION, AND TO GIVE UP MY RIGHT TO LITIGATION; THAT NOTHING, EXPRESS OR IMPLIED, VERBAL OR WRITTEN, SHALL SUPERCEDE OR ALTER THIS CONSENT, RELEASE, AND INDEMNITY AGREEMENT IN ANY WAY; AND THAT I AM SIGNING BELOW FREELY AND VOLUNTARILY AND WITHOUT COERCION.

Name: _____ Signature: _____ Date: ____/____/____

Staff: _____ Signature: _____ Date: ____/____/____

Medical Director: **Glen D. Blomstrom, M.D.** Signature: _____ Date: ____/____/____