Bluffton Aesthetics

Name:	**Date of Birth:**
Address:	**Email:**
City: **State:** **Zip Code:**	**Emergency Contact:**
Phone:	**Emergency Phone:**
How did you hear about us?	**Referral Name:**

General Health

1. Are you pregnant or nursing? Yes No

2. Do you wear contact lenses? Yes No

3. Do you smoke? Yes No How many cigarettes per day? ____ Drink? Yes No

4. Please list any accidents or surgeries in the last 9 months:

5. Do you have any metal implants, a pacemaker or body piercings?

6. List the medications you are currently taking:

Prescription	Over the Counter

Health History

Have you had any of the following conditions:

- ☐ Acne
- ☐ Arthritis
- ☐ Diabetes
- ☐ Rosacea
- ☐ Hypertrophic Scaring
- ☐ Thyroid Disease
- ☐ Immune Disorder
- ☐ Cold Sores/Fever Blisters
- ☐ Seizures
- ☐ Cancer
- ☐ Bleeding Disorder
- ☐ Asthma
- ☐ Heart Conditions
- ☐ Pacemaker/Metal Implants
- ☐ Hepatitis
- ☐ Staff Infection/MRSA
- ☐ HIV/Aids
- ☐ Skin Disorders (dermatitis, eczema, etc)

Allergies (Food, Latex, Medications, or Metals) Please list:

_____

_____

Skin Care

1. Do you use sunscreen? ☐ Yes ☐ No How Often? What SPF?

2. Are you active outside? ☐ Yes ☐ No What Activities?

3. Do you use tanning beds or lay in the sun? ☐ Yes ☐ No If yes, how often?

Skin Maintenance

How would you describe your skin? ☐ Oily ☐ Sensitive ☐ Dry ☐ Normal ☐ Combination

Have you received any of the following procedures?

☐ Chemical Peel	☐ Waxing	☐ Microdermabrasion
☐ Dermaplaning	☐ Facial	☐ Laser treatments
☐ Tattoo Removal	☐ Microneedling	☐ Botox/fillers

Date of last treatment: _____

Other (if yes, explain): _____

Have you used any of the following topical/oral medications?

☐ Accutane	☐ Differin	☐ Hydroquinonine
☐ Topical Antibiotics	☐ Tazarac	☐ Retin-A
☐ Tretinoin	☐ EpiDuo	

What concerns do you have?

☐ Aging Skin	☐ Dry Skin	☐ Acne
☐ Brown Spots	☐ Spider Veins	☐ Scars
☐ Stretchmarks	☐ Rough Texture	☐ Rosacea
☐ Unwanted Hair	☐ Enlarged Pores	☐ Thin Lips
☐ Redness	☐ Sun Damage	☐ Fine Lines/Wrinkles
☐ Tattoo Removal	☐ Other: _____	

What are your skin concerns and goals:

_____

_____

What are skin products you are currently using? Please include makeup.

_____

_____

Do you have any other medical concerns that have not been covered on this form? If yes, please explain:

_____

_____

I understand that the objective of any cosmetic procedure is an improvement and results may vary.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Bluffton Aesthetics

HIPPA Notice

Uses and Disclosures:

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of treatments will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Bluffton Aesthetics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's public health department.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

1. the right to request restrictions on the use and disclosure of your protected health information
2. the right to receive confidential communications concerning your medical condition and treatment.
3. the right to inspect and copy your protected health information/
4. the right to amend or submit corrections to your protected health information
5. the right to receive an accounting of how and to whom your protected health information has been disclosed.
6. the right to receive a printed copy of this notice.

Bluffton Aesthetics Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revise notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information by submitted in writing. You may obtain a form to request access to your records by contacting our receptionists or our office manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
Bluffton Aesthetics
Post Office Box 3828
Bluffton, SC 29910

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.
Contact Person
Effective Date: This notice is effective on or after April 14, 2003

Acknowledgement of Receipt of Notice of Privacy Practices

Bluffton Aesthetics reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Bluffton Aesthetics

Patient Name (Printed): _____ Date_____

Signature _____

HIPAA PERMISSIONS

May we leave messages on your voicemail with your specific appointment information?

☐ Yes ☐ No

May we release your complete medical records to your referring physician and/or your primary care physician?

☐ Yes ☐ No

I, the patient hereby authorizes Bluffton Aesthetics to release my medical information (appointments, treatments, products, medications etc.) via postal mail, telephone, fax, or email to the following family members:

Name	Date of Birth	Relationship

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor	Phone #	Clinic

Bluffton Aesthetics

Authorization For Procedures

Patient Name: _____ DOB: _____

1. I give any licensed, trained staff of Bluffton Aesthetics permission to perform any of the following but not limited to procedures: Tattoo removal, laser hair removal, Botox, Filler, IPL, Photofractional, ResurFX, Chemical Peels, Oxygen Facials, Q-Switch, Microblading, Microneedling, Waxing, and Dermaplanning.
2. I understand that during the procedure(s) new findings or conditions may appear and require an additional procedure(s) for proper care.
3. My practitioner/esthetician has discussed with me the items listed below:
    a. The nature of my condition
    b. The nature and purpose of the procedure(s) that I am now authorizing;
    c. The possible complications and side effects that may result, problems which may be experienced during recuperation, and the likelihood of success;
    d. The benefits to be reasonably expected from the procedure(s);
    e. The likely result of no treatment; and
    f. The available alternatives, including risks and benefits.
    g. My practitioner/esthetician has also explained that, in addition to the specific risks involved in the procedure(s), there are other possible risks that accompany any laser and ablative procedure. I understand these risks are no an exhaustive list of every risk possible. I acknowledge that neither my practitioner/esthetician nor anyone else involved in my care has made any guarantees or assurances to me as to the result of the procedure(s) that I am now authorizing.
    h. I have received pre/post care instructions and understand all questions have been answered.
4. I understand my procedure(s) may be photographed or videotaped and that observers may be present in the room for the purpose of advancing medical care and education; and that my identity will not be revealed in said photos or videos.
5. I understand and accept the following financial agreement: The entire cost of each procedure is to be paid in full at the time of service. This may be paid in cash, pre-approved check, Mastercard/Visa, or Care Credit. Elective cosmetic procedures are not covered by insurance. Packages must be paid in advance and are nonrefundable.

I understand what my practitioner/esthetician has explained to me and I have had all my questions fully answered. Having talked with my practitioner/esthetician and having the opportunity to read this form, my signature below acknowledged my consent to the performance of the procedure(s) (both present and future services) described above.

Signature of patient _____ Date _____

I have explained the risk, benefits, potential complications, and alternatives of the treatment(s) to the patient and have answered all questions to the patient's satisfaction, and he/she has grated consent to proceed.

Signature of practitioner/esthetician _____ Date _____