

**Client Information Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Suite/Apt#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home# : \_\_\_\_\_ Work#: \_\_\_\_\_ Cell#: \_\_\_\_\_  
Preferred number for contact and appointment reminders: H W C  
Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_  
Do you have any medical conditions? \_\_\_\_\_  
Are you pregnant? \_\_\_\_\_ If so, how many months? \_\_\_\_\_  
Do you have any current heart problems? \_\_\_\_\_  
Are you currently taking any medications? \_\_\_\_\_  
Do you take or use Accutane? \_\_\_\_\_ Retin-A? \_\_\_\_\_ Glycolic Acid? \_\_\_\_\_  
Do you have any allergies? (please list) \_\_\_\_\_  
What skin care products do you currently use? \_\_\_\_\_  
When did you use these last? \_\_\_\_\_  
Treatment desired? \_\_\_\_\_  
Reason for treatment? \_\_\_\_\_

**CANCELLATIONS**  
Your scheduled appointment is reserved exclusively for you. Should you need to cancel or reschedule your appointment, please notify us 24 hours in advance to avoid a charge for 50% of treatment scheduled. All services re-scheduled or cancelled on same day of appointment or missed without notice will be charged 100% of treatment price.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Skin Health Expert Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Renew Skin. Restore Health. Deliver Results.**

**Client Contraindications Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please answer ALL of the following questions:**

Pacemaker	Yes	No	
Pregnancy	Yes	No	
Cancer	Yes	No	If yes, please explain _____
Tumors	Yes	No	If yes, please explain _____
Epilepsy	Yes	No	
Heart Condition	Yes	No	If yes, please explain _____
High Blood Pressure	Yes	No	
Diabetes	Yes	No	
Inflammation/Infection	Yes	No	If yes, please explain _____
Autoimmunity Disorder	Yes	No	If yes, please explain _____
Multiple sclerosis	Yes	No	
Muscular condition	Yes	No	If yes, please explain _____
Varicose Veins	Yes	No	
Allergy – Rubber/Metals	Yes	No	
Lack of normal skin sensation	Yes	No	
Skin Diseases	Yes	No	If yes, please explain _____
Thrombosis/Phlebitis	Yes	No	
Metal implants/Screws	Yes	No	If yes, please explain _____
Prosthesis/Silicone	Yes	No	If yes, please explain _____

Any other medical conditions that are not listed? \_\_\_\_\_

**Consent and Agreement:**

I certify that the above statements are true and correct and that I having been fully advised by Kate Somerville Skin Health Experts LLC concerning the nature of the treatment process proposed to be administered by them, hereby authorize and direct them to administer such procedures as may be deemed necessary or advisable.

My signature below constitutes my acknowledgement that (1) I have read, understand, and fully agree to the foregoing consent; (2) the proposed treatment process has been satisfactorily explained to me and I have all the information which I desire; and (3) I hereby give my consent and authorization and release this establishment and its agents of any claims that I have in the future in connection with the described treatment.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Skin Health Expert Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent to Photograph**

The undersigned hereby authorized Kate Somerville Skin Health Experts LLC to photograph and agrees that the negatives, print or digital images prepared therefrom may be used for the purposes checked:

Medical Record     Education and/or Demonstration     Publication     Other specified \_\_\_\_\_

I have read and understand this agreement:

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

**OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (01/01/05), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

#### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$.0 for each page, \$0 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. Please provide a Self-Addressed, Stamped Envelope along with your letter of authorization. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

#### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## Cosmetic Interest Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

**General appearance or skin concerns (please check all that apply)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Skin rejuvenation                      | <input type="checkbox"/> Facial redness                | <input type="checkbox"/> Arms            |
| <input type="checkbox"/> Fine lines and wrinkles                | <input type="checkbox"/> Brown spots/hyperpigmentation | <input type="checkbox"/> Abdominal area  |
| <input type="checkbox"/> Facial folds –around mouth and/or nose | <input type="checkbox"/> Dark circles under eyes       | <input type="checkbox"/> Thighs          |
| <input type="checkbox"/> Rough texture of skin                  | <input type="checkbox"/> Thin lips                     | <input type="checkbox"/> Cellulite       |
| <input type="checkbox"/> Tired looking skin                     | <input type="checkbox"/> Acne                          | <input type="checkbox"/> Lose Body Skin  |
| <input type="checkbox"/> Dry skin                               | <input type="checkbox"/> Facial or leg veins           | <input type="checkbox"/> Body Laxity     |
| <input type="checkbox"/> Sagging skin                           | <input type="checkbox"/> Unwanted hair                 | <input type="checkbox"/> Body Acne       |
| <input type="checkbox"/> Uneven skin tone                       | <input type="checkbox"/> Neck laxity                   | <input type="checkbox"/> Thinning Lashes |

**Please rank your top five concerns**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Comments**

- 
- 
- 
- 
- 

**Products or treatments of interest to you (please check all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> Skin care advice             | <input type="checkbox"/> Facial muscle toning                                 |
| <input type="checkbox"/> Skin care products           | <input type="checkbox"/> Depigmentation                                       |
| <input type="checkbox"/> Laser treatments             | <input type="checkbox"/> BOTOX® Cosmetic                                      |
| <input type="checkbox"/> Hair removal                 | <input type="checkbox"/> Fillers (Juvéderm®, Restylane®, Perlane®, Radiesse®) |
| <input type="checkbox"/> Removing leg or facial veins | <input type="checkbox"/> Facial Fullness                                      |
| <input type="checkbox"/> Eye treatments               | <input type="checkbox"/> Retin-A  |
| <input type="checkbox"/> Facials                      | <input type="checkbox"/> Lightening cream                                     |
| <input type="checkbox"/> Peels                        | <input type="checkbox"/> Body treatments (wraps and/or Lipocell)              |
|   | <input type="checkbox"/> Latisse®   |

**Please answer the following questions on a scale from 1 to 5 by circling the appropriate number**

When I look at my face in the mirror, I believe I look younger, the same, or older than my true age?

Younger than True Age Older than

1 2 3 4 5

When looking in the mirror, I am concerned, somewhat concerned, or very concerned about the appearance of my wrinkles and/or skin laxity?

Not Concerned Somewhat concerned Very Concerned

1 2 3 4 5

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