Heron Med Spa services

Client Name:_____Date: _____

Street Address:_____

City:_____ State:_____Zip Code: _____

Date of Birth:___/____/____ Gender: Female ____ Male_____

Telephone: Home:_____ Work: _____

Mobile:_____ Email: _____

Emergency contact:_____ Relationship: _____ Phone

1. Please check all those below that apply:

	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

Medical History

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

___Heart disease

___Diabetes

___Auto-immune disease

___Hypertension

___Hepatitis

___Use tobacco products

___Active cold sores, herpes simplex or warts (primarily the mouth)

___Endocrine/Hormonal disorder

___History of radiation therapy in application area

___Wear contact lenses

___Current or recent pregnancy

___Easy bleeding/bruising

___Delayed or abnormal wound healing, sunburned or excessively sensitive skin

____Other _____

2. List any current medical problems:

_____

3. List medications/vitamins 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: _____

_____

_____

Signature/Date:

_____

INFORMATION AND CONSENT FORM
Use of ICON™ Laser MAX G for Dermatological Procedures

For years, Photo Facial treatments (IPL) with the **ICON™ MAX G** has been used to effectively and safely treat a variety of cosmetic skin problems. The treatments are simple office procedures performed by highly trained medical laser technicians. The technicians will asses with you clear goals and what it will take to achieve your goals. Your goals may require 2-3 treatments for optimal skin rejuvenation.

Following your treatment, there MAY be a minor degree of redness and puffiness to the skin, with some tingling discomfort that usually disappears in 1-2 hours. You may apply makeup immediately after treatment and return to work or regular activities. **It is highly recommended that you begin a comprehensive skin care program to optimize the cosmetic improvements you obtain with your photo facial.**

Every cosmetic laser procedure involves a very small degree of risk and although uncommon, it is important that you understand and accept the rare risk involved with your treatments. Although a vast majority of patients do not ever experience any of these complications, you may discuss each of them with your laser technician to ensure you fully understand the risk and potential complications and average outcome of these procedures.

I understand the following risks:

- Some patients experience a various degree of discomfort. Some describe the sensation as a stinging, while others say it's like a rubber band snap. A burning sensation may last for up to a few hours after treatment. Most patients can tolerate this discomfort, but some patients may request numbing cream (an additional $50 charge). **Initial here: _____**

- It is rare for the **MAX G** to cause a blister or skin wound. The incidence of blistering or crusting is less the 3% overall. If a blister or skin wound develops, it may take up to five to ten days for it to heal, and in EXTREMLY rare instances, may leave noticeable whitening or darkening of the skin. **Initial here: _____**

- There is a very small risk of temporary hyper pigmentation (increase in pigment) or hypo pigmentation (lighting of skin) in the treated area. Hyper & hypo pigmentation is found in less than 1% in skin types 1-3 on the Fitzpatrick types. Usually, these results are temporary and will resolve over several weeks or months. **Initial here: _____**

- It is essential that you do not tan your skin or use tanning cream or spray prior to or following your treatments as this will increase your risk of pigment change or skin wounds. **Initial here: _____**

- Scarring occurs in less than 0.1% If you develop a wound, it is important to return to Heron Med Spa to keep it from scarring. **Initial here: _____**

- It is extremely uncommon to have any skin bruising following a treatment. If bruising occurs, it can be camouflaged immediately. Bruising should resolve in 8-10 days. **Initial here: _____**

- A minor degree of puffiness and or swelling may follow a treatment that usually last up to two hours. A mild hydrocortisone cream will usually settle this.
Initial here: _____

- A photo facial cannot be performed during pregnancy. **Initial here: _____**

I acknowledge that I am obligated to follow the instructions closely and if needed to visit the office as directed. I agree all my questions have been addressed to my satisfaction. I understand the payment required for this treatment and the recommendation for proper skin care associated with this procedure. I give permission to the laser tech to perform the IPL photo facial and will hold her and her staff harmless from any liability that may result from this treatment.

Treatment #1

_____

Client Name (printed)

_____Date_____

Client Name (signature)

Technician: _____

Treatment #2

_____

Client Name (printed)

_____Date_____

Client Name (signature)

Technician: _____

Treatment #3

_____

Client Name (printed)

_____Date_____

Client Name (signature)

Technician: _____

Marketing Authorization and Use of Photographs

According to federal law **we must ask for your permission to send to you via email, text, social media 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, Open House invitations).

Our office DOES NOT SELL or SHARE our patient's 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 Heron Med Spa in writing or email. I understand that my revocation or modification of this authorization will not affect any actions taken by Heron Med Spa in reliance on this authorization before Heron Med Spa receives my request for revocation or modification. I must sign my written request and send it to:

Privacy Contact
Heron Med Spa, 321 South Patrick Street, Alexandria, VA 22314

I **DO**_____ I **DO NOT**_____ **Please select one**

Authorize Heron Med Spa services or promotions the practice offers. You may choose email, cell phone or both.

I **DO**_____ I **DO NOT**_____ **Please select one**

Authorize Heron Med Spa to use my photographs.

_____ _____

Patient Signature Date

_____

Email Address Please Print

_____

Cell Phone Number

Cancellation, Missed Appointment, and Deposit Policies

Please realize that with all appointments, we have reserved time on our schedule especially for you. When an appointment is cancelled with late notice, or missed entirely, this time cannot be used for anyone else. Therefore, ***we require 24-hour notice*** *be given for cancellation of all appointments. If an appointment is canceled with less than 24-hour notice, or if an appointment is missed altogether, a fee will be assessed for this cancelled/missed appointment. No emails please ~* ***Call 703-549-2626 and leave a message****. Additionally, a deposit may be required to reserve a future appointment.*

Cancellation for SculpSure, ThermiVa Treatments and Laser Appointments

Due to the significant amount of time reserved for particular treatments, a deposit of $100 is required at the time of scheduling to reserve an appointment over 45 minutes. This deposit will be applied in full to the treatment, provided the appointment is kept. If the appointment is cancelled with more than 24-hour notice, the deposit will be credited to your account for a future appointment or refunded if you chose. If the appointment is cancelled with less than 24-hour notice, or if the appointment time is missed, the $100 deposit will be retained as a cancellation/ missed appointment fee.

Signature_____ Date_____

COMPLIANCE NOTIFICATION TO OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and costing money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine the appropriate use of PHI in accordance to the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I read the Notice of Privacy Practices and that I have read and understand the Notice.

_____ Date _____

Patient Signature