CosMedic SKINCARE

JODIE REINERTSON, MD

Thank you for joining us at CosMedic Skincare! We are glad you are here!

~ Please check the <u>FIRST</u> way in which you heard about us ~

▪ Internet :

- ☐ Google.com
- ☐ Yelp.com
- ☐ Dermsnextdoor.com
- ☐ Latisse.com
- ☐ Sculptra Aesthetic website
- ☐ Isolaz Therapy – Stop the Pop Website
- ☐ The Center for Medical Weight Loss Website
- ☐ Citysearch.com
- ☐ Yahoo.com
- ☐ Bing.com
- ☐ Radiesse.com
- ☐ Vioramed.com
- ☐ Facebook
- ☐ Other: _____

▪ Magazine/Newspaper :

- ☐ Seattle Metropolitan Magazine
- ☐ Seattle Magazine
- ☐ UW Daily Newspaper
- ☐ Other: _____

▪ Friends of CosMedic Skincare :

- ☐ Advance Skin & Body Solutions
- ☐ Dr. Daniel McKay, DDS
- ☐ Cabrini Medical Tower
- ☐ Other: _____

▪ Other : (please specify below)

- ☐ Friend: _____
- ☐ Relative: _____
- ☐ Other: _____

PATIENT INFORMATION:

PATIENT NAME :			**DATE OF BIRTH:**
ADDRESS:		**CITY & STATE:**	**ZIP CODE:**
PREFERRED CONTACT NUMBER:	**SECONDARY CONTACT NUMBER:**	**3RD CONTACT NUMBER:**	
EMPLOYER:		**PARTNER/SPOUSE NAME:**	
EMAIL ADDRESS:		*Your email address will only be used for in-office communication and will not be sold or given to any 3rd party individual or organization.*	
☐ PLEASE CHECK HERE IF YOU WOULD LIKE TO JOIN OUR *PATIENT RECOGNITION PROGRAM.* E-MAIL NEWSLETTER IS SENT ONCE A MONTH			

RESPONSIBLE PARTY (Required for Minors):

NAME:	**RELATION:**
ADDRESS, CITY, STATE, ZIP:	**CONTACT NUMBER:**

IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME:		**RELATION:**
HOME PHONE:	**WORK PHONE:**	**CELL PHONE:**

FINANCIAL RESPONSIBILITY AGREEMENT:

- We are not contracted with any insurance company; however, we can provide a superbill to submit to your insurance company for reimbursement. Ultimately, you will assume full financial responsibility.
- Payment is due at the time of service. We accept payment in the form of cash, AMEX, Visa, MasterCard & Discover.
- Payment plans are available through third party financing groups.
- NO SHOWS may be subjected to a fee of $50 if appointment is not cancelled at least 24 hours in advance.
- A deposit must be taken for major procedures. Sculptra Aesthetic procedures require a $200 deposit.

I further understand that providing proof of my insurance plan(s) or explanation of benefits does not hold CosMedic Skincare responsible for verifying this information. I accept full financial responsibility for medical expenses incurred at the CosMedic Skincare for all services provided. In the event where it is necessary to refer my account to an attorney for collection, I am responsible for all fees and expenses.

_____ _____/_____/_____

Signature (If under 18, must be signed by parent/guardian) Date

_____

If parent/guardian, print name

Procedures or products of interest to you (please check all that apply)

- ❑ Dermal Filler for accentuating facial features and correcting folds and wrinkles (Juvederm, Radiesse, & Voluma)
- ❑ BOTOX for Wrinkles
- ❑ BOTOX for Excessive Sweating
- ❑ Viora Reaction for Skin Tightening
- ❑ Laser/Light Treatments for Treating Pigment and/or Age Spots
- ❑ HydraFacial MD to Promote Smooth, Healthy Skin
- ❑ Microdermabrasion
- ❑ Medical Weight Loss Program
- ❑ Sculptra Aesthetic for Collagen Production
- ❑ Sclerotherapy for Spider Veins
- ❑ Melanage Peel for Melasma
- ❑ Laser Hair Removal
- ❑ Skin Resurfacing with DOT Therapy
- ❑ Eyebrow Waxing or Tinting
- ❑ Chemical Peels
- ❑ Medical-Grade Skincare

❑ Other, Please Specify: _____

HEALTH HISTORY QUESTIONNAIRE

Thank you for taking the time to complete this questionnaire. The information you provide will help us attend to your specific health care needs. We value your input and your participation in your medical care.

NAME: _____ **AGE:** _____

MY SKIN IS GENERALLY (Please check all that apply)**:**

- ❑ Acne Scars
- ❑ Big Pores
- ❑ Blotchy
- ❑ Broken Capillaries
- ❑ Cysts
- ❑ Dark Circles
- ❑ Acne
- ❑ Dry Skin
- ❑ Blushes Easily
- ❑ Excess Hair
- ❑ Flaky
- ❑ Tans Easily
- ❑ Hyperpigments Easily
- ❑ Oily
- ❑ Puffy Eyes
- ❑ Wrinkles
- ❑ Sensitive
- ❑ Herpes
- ❑ Skin Tags
- ❑ Spider Veins
- ❑ Sun Damage
- ❑ Skin Cancer/ Pre-Cancer
- ❑ Warts
- ❑ Allergies

Please list all concerns that relate to your skin:

_____

_____

What is your current skin care regimen?

Face: _____

Body: _____

What treatments/medications (if any) have you used for the conditions checked above?

Topical_____Oral_____

How long have you had this/these condition(s)? _____

What **medications, vitamins and/or supplements** are you currently taking?

_____

PATIENT HISTORY:

Primary Physician: _____ Hospital/Clinic: _____

Last Physical: _____ Last Blood Work: _____

Drug Allergies: _____ **Food Allergies:** _____

Past Medical History: _____

Past Surgical History: _____

Women Menstrual Cycle is _____ Regular or ____Irregular

#of Children: _____ ☐ On Birth Control ☐Planning Children ☐Pregnant ☐Nursing

FAMILY HISTORY:

❑Acne ❑Rosacea ❑Psoriasis ❑Diabetes ❑Thyroid ❑Rashes ❑Depression ❑Melanoma ❑Moles

❑Heart Problems ❑High Blood Pressure ❑High Cholesterol ❑Pre-Cancer ❑Skin Cancer

Major family health issues? _____

_____

Before and After Photo Release

for *Cosmedic Skincare and The Center for Medical Weight Loss*

I consent to being photographed before, after, and potentially during any procedures at Cosmedic Skincare. I understand that these photographs will become part of my confidential medical record. I understand that the images are the property of CosMedic Skincare but I may request copies for a nominal fee.

Please <u>initial</u> all that apply:

___ I give my consent for the physician to use my pictures at medical meetings and/or in the publications of medical article(s).

___ I give my consent for the physician to use pictures of my procedure results to show other individuals interested in the same procedure so long as my name is kept confidential.

___ I give my consent for the physician to place my picture on Cosmedic Skincare's website <u>www.seattlecosmedicskincare.com</u> as long as my name is kept confidential.

___ I give my consent for my photos to be used for print and marketing purposes.

___ I give my consent to have my pictures taken to be kept for my records.

Print Name: _____

Signature: _____ Date: _____/_____/_____

Appointment Cancellation Policy

In an effort to provide the best service possible for all of our patients, we have the following cancellation policy for all appointments:

We request 24-hour notice if you wish to cancel or reschedule your appointment. If you are booked for a major procedure, we request 72-hour notice. This enables us to respond to the higher demand over availability for appointments.

Patients who cancel or reschedule in less than the required time, or do not show for their scheduled appointments, will be charged a $50 fee since we are unable to offer that time to another patient.

Patients will either be charged the fee at their next visit or in special circumstances, they will be required to pay a $50 deposit to secure a future appointment.

The cancellation fee is non-refundable, non-transferrable, and due in-full at the subsequent treatment date.

By signing below I agree that I was informed of this policy and I understand it.

X_____

_____
Print Name

Date: _____/_____/_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / HIPAA

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed by Cosmedic Skincare and the Center for Medical Weight Loss. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 206-622-6444 or by requesting one at this office.

_____/_____/_____ _____

Date Signature

_____

Print Name (If minor, complete below)

- As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____/_____/_____ _____

Date Signature

_____

Relationship