PATIENT NAME: _____

Date of Birth_____ Age:_____ Gender : Male Female

Address:_____

City/State/Zip: _____

Primary Phone: _____ Home Work Cell

Secondary Phone:_____ Home Work Cell

Emergency contact name: _____Primary Number_____

HOW DID YOU HEAR ABOUT US? (Please check all that apply)

____ RADIO: STATION_____
____ WEBSITE: DERMATOLOGYCENTER.COM, GOOGLE_____
____ OUTDOOR SIGN: _____
____ FRIEND/FAMILY: _____
____ NEWSPAPER/AD: _____
____ MEDICAL PATIENT: _____
____ OTHER: _____

I WOULD LIKE TO RECEIVE EMAILS REGARDING GLOWMD LASER MEDSPAS UPCOMING EVENTS AND SPECIALS. _____YES _____NO

Email Address: _____

Are you a member of Brilliant Distinctions? Yes No **Are you a member of Aspire**? Yes No

Brilliant Distinctions Member number #_____

_____ _____

SIGNATURE DATE

TREATMENTS: All treatments are considered to be cosmetic, and will not be filed with your insurance company.

CONSULTATIONS: We offer complimentary consultations with our laser and skin care specialist or an esthetician is provided to help determine what procedures may be most beneficial to help you to achieve your skin care goals.

DEPOSITS: A non-refundable deposit is required to schedule a procedure. Procedures that are less than $100 are to be paid in full to schedule the appointment. All other procedures require $100 deposit and the remaining balance must be paid in full at the time of service. Fractora and Coolsculpting requires a $500 non-refundable deposit and the balance is to be paid in full at the time of the appointment. CoolSculpting requires a $500.00 deposit, but balance must be paid in full 10 days prior to treatment.

I authorize any outstanding balance to be charged to my credit card listed below and to send me a copy of the transaction receipt:

Circle One: Visa MasterCard American Express Discover

Card Number _____

Expiration Date_____

Name of Card Holder_____

Security Code _____ Your Zip Code_____

Responsible Party _____ Date ___/___ / ____

PAYMENTS: Payment in full is due at the time of service. We accept cash, personal checks, credit cards(Visa, MasterCard, American Express and Discover). We also accept Care Credit financing as a form of payment.

Packages purchased will expire 1 year from date of purchase.

MISSED APPOINTMENTS: You are responsible for keeping track of your appointments. Cancellations require at least 24 hour notice to the appointment time. Failure to call 24 hours in advance to cancel or reschedule your appointment will result in loss of your deposit. Package treatments that are missed, canceled or rescheduled less than 24 hours in advance will be considered "skipped treatments" and will not be rescheduled.

Return Policy

Your satisfaction is a main concern of ours. If you are not satisfied with a product you purchased here at glowMD Laser MedSpa, please contact us right away. We are pleased to accept returns within 30 days of purchase for a refund. Sorry, no returns on prescription products. Gift cards are not refundable.

Your signature below indicates your understanding and willingness to comply with this policy. Please ask a staff member if you have questions.

_____ _____

RESPONSIBLE PARTY **DATE**

Glow MD Laser MedSpa
Skincare Intake Form

Date:_____

Name:_____ Date of Birth:_____

1. What is your main concern for today's visit: _____

2. Do you currently or have you ever had any of the following? (circle all that apply)

Dry skin Excessive oil Sensitivities Acne Cystic acne

Pigmentation Visible capillaries Fine lines Wrinkles Cold sores

Whiteheads Blackheads Skin cancer or family history of skin cancer

List any additional skin concerns you may have:_____

_____

3. What products do you currently use and how often (once a day, twice a day, morning/night)?

_____

4. What is the name of your primary care physician? _____

Flu Vaccination: (*Last date given*) Pneumonia Vaccination: (*Last date given*)

Date _____ Date _____

5. List any medications you currently take w/dose and instructions:

_____

_____

_____

_____

6. List any allergies:_____

_____

7. Are you using Retin-A, Tretinoin or Renova? Yes ☐ No ☐

8. Are you pregnant? Yes ☐ No ☐ Nursing? Yes ☐ No ☐

9. Are you a smoker? Yes ☐ No ☐ Prior How Often_____

10. How often do you consume the following?

Water _____ glasses per day Soda _____ glasses per day

Coffee/Tea ____cups per day Alcoholic beverages ____ per week

11. Do you feel you maintain a healthy diet? Yes ☐ No ☐

12. On a scale of 1-10, rate your stress level: _____

13. Have you ever had a reaction to a skin care product? Yes ☐ No ☐

If so, what and when? _____

_____

14. Have you ever had a skin treatment before? Yes ☐ No ☐

If so, what and when? _____

15. When exposed to the sun do you: Burn only Burn and Tan Tan only

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, glowMD Laser MedSpa may use and disclose protected health information (PHI) about me to carry out **treatment, payment and healthcare operations (TPO).** I have the right to review the Notice of Privacy Practices prior to signing this consent. GlowMD Laser MedSpa reserves the right to revise its Notice of Privacy Practices at any time. A Notice of Privacy Practices may be obtained by forwarding a written request to: Office Manager, The Dermatology Center, 3501 Lafayette Blvd., Fredericksburg, VA 22408.

I,_____, hereby authorize glowMD Laser MedSpa, and/or their representatives to release any and all information pertaining to my healthcare, results, procedures, and/or accounting information to the following person(s) or agencies:

- ☐ Myself only
- ☐ Spouse, full name:_____
- ☐ Parent, full name(s) _____
- ☐ Other(s) – Specify name and relationship _____

May leave a message:

- ☐ At home
- ☐ At work
- ☐ On answering machine at home and/or work

Email me: _____

I understand that this office will release any information to those persons who I have determined may receive this information without separate consent. I also understand that this relates to all spa /billing/account information. **THIS WILL BE ACTIVELY ENFORCED**. If you wish to change the status of this form, you must do so in writing.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, GlowMD Laser MedSpa may decline to provide treatment to me.**

_____Date_____
Print Patient's Name

_____
Signature of Patient, Responsible Party, or Legal Guardian

Patient Declined to Sign_____ GlowMD Laser MedSpa _____