healthfinity
Aesthetics

PATIENT REGISTRATION FORM

Today's Date: _____

Name: [First] _____ [M.I.] _____ [Last] _____ ☐ Male ☐ Female

Address: _____ [Apt.] _____ Age: _____ DOB: ____ /____ /____

City: _____ State: _____ Zip: _____ Home Tel: _____

Social Security #: _____ Driver's License #: _____ Work Tel: _____

E-mail: _____ Race: _____ Mobile Tel: _____

OK to leave a message on Home Phone? ☐ Yes ☐ No | On cell Phone? ☐ Yes ☐ No | With another person? ☐ Yes ☐ No

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State _____ Zip_____

Work Number: _____ Work fax: _____

Marital Status: ☐ Single ☐ Married ☐ Other Spouses name: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Tel: _____ Work Tel: _____ Mobile Tel: _____

Does this person have your permission to discuss your private health information? ☐Yes ☐No

PHARMACY PREFERENCE

Name of Pharmacy: _____ Address/Cross Streets: _____

Tel: _____ Fax: _____

REFERRAL SOURCE: HOW DID YOU HEAR ABOUT HEALTHFINITY?

Internet keywords used: _____ on Website: □Google □RealSelf □Yelp □Facebook □Instagram

□Other Website: _____

□Doctor Referral: _____ □Patient Referral_____

INSURANCE INFORMATION

Responsible Party: _____ Social Security #: _____DOB:_____

Employer: _____ Occupation: _____ Relation to Patient: _____

Home Address: _____City:_____ State: _____ Zip: _____

Home Tel: _____ Work Tel: _____ Mobile Tel: _____

Primary Insurance (If applicable): _____ Telephone: _____

Policy Holders Name: _____ DOB: _____ Group #: _____ ID# _____

I hereby acknowledge I was offered a copy of your notice of privacy practices. _____ Initial

INSURANCE INFORMATION CONTINUED

Secondary Insurance (If Applicable): _____ Telephone: _____

Policy Holders Name: _____ Relation to Patient: _____

DOB: _____ Group #: _____ ID# _____

I understand that office visit charges and/or co-pays are payable on the day service is rendered. I authorize Healthfinity to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Healthfinity and myself.

Signature (patient, Parent or Guardian: _____ Date: _____

PROCEDURE INFORMATION

Face	Skin	Body
__ Face Lift __ Cheek Lift __ Brow Lift __ Neck Lift __ Liquid Face Lift __Other: _____ __Other: _____	__ Botox __ Facial Fillers __ Juvéderm __ Restylane/Perlane __ Radiesse __ VOLUMA __ Kybella __ Skin Resurfacing __ Skin Tightening __ Facials __ Hand Rejuvenation __ Skin Care __ Latisse __ Other: _____ __ Other: _____	__ Body Lift __ Arm Lift __ Thigh Lift __ Cellulite Reduction __ Laser Hair Removal __ Stem Cell __PRP Hair Restoration __ Other: _____ __Other: _____

Please describe why you are interested in having the procedure(s) listed above: _____

_____

Have you consulted with other physicians/practitioners about procedure(s) indicated above? ☐ Yes ☐ No

Is this a revision from a previous surgery? ☐ Yes ☐ No If yes, how many previous surgeries? _____

What is your time frame for your procedure? ☐ 1 Month ☐ 3 Months ☐ 6 Months ☐ 1 year

SOCIAL HISTORY

☐ I am a non-smoker and I do not use nicotine products. ☐ I am a former smoker and I stopped approximately _____ years ago.

☐ I am a smoker and I use tobacco/Nicotine products (gum, patches, vapor, marijuana), Frequency? _____ per day.

Do you drink? □Yes □No Frequency? _____ drinks per week. Number of pregnancies? _____ Ages of children? _____

Did you breastfeed? □Yes □No Date of last menstrual period? _____ Are you trying to become pregnant? □Yes □No

MEDICAL HISTORY

Height: _____ Weight: _____ BMI: _____(staff will complete)

List all Allergies: _____

List all Medications you are taking: _____

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MEDICAL HISTORY CONTINUED

Do you have any of the following?	YES	NO		YES	NO
1. Allergy to tape?	☐	☐	2. Do you wear contact lenses?	☐	☐
3. Have you ever had a blood transfusion?	☐	☐	4. Is there any chance you are pregnant?	☐	☐
5. Do you wear dentures?	☐	☐	6. Any reaction to anesthesia?	☐	☐
7. Are you being treated for any illness?	☐	☐	8. Any past serious Illnesses?	☐	☐
If yes, explain: _____			If yes, explain: _____		
_____			_____		
9. Are you presently in good health?	☐	☐	10. Date of last exam? _____		
11. Are you taking hormone therapy?	☐	☐	12. Do you have a history of cold sores?	☐	☐
(Including birth control) _____			How often, last break out, how do you treat?		
_____			_____		
13. Have you ever taken Accutane?	☐	☐			
If so when: _____					

Please list all previous surgeries and major hospitalizations:

Date:	Reason:	Place:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any history of the following:

☐ HEADACHES	☐ HIGH BLOOD PRESSURE	☐ REPRODUCTIVE DISORDER	☐ HIV OR AIDS
☐ DIABETES	☐ GLAUCOMA	☐ PSYCHIATRIC DISORDERS	☐ STREET DRUGS
☐ STROKE	☐ HEART DISEASE	☐ BLEEDING DISORDERS	☐ KIDNEY DISEASE
☐ HEPATITIS	☐ HEART FAILURE	☐ EMOTIONAL PROBLEMS	☐ SEIZURES
☐ ASTHMA	☐ CHEST PAIN	☐ BLEEDING DISORDERS	☐ LIVER PROBLEMS
☐ EMPHYSEMA	☐ GASTRIC REFLUX	☐ STOMACH PROBLEMS	☐ CANCER
☐ ULCERS	☐ LUNG PROBLEMS	☐ COMMUNICABLE DISEASE	☐ BAD SCARRING
☐ THYROID	☐ CIRCULATORY	☐ FREQUENT INFECTIONS	☐ SERIOUS INJURIES

Any family history of: ____ Cancer ____ Diabetes _____ Heart problems _____ Anesthetic Problems

Is there any personal history of anesthetic complications or malignant hypothermia?
If yes, please explain? _____

SKIN CARE PATIENTS

Have you had any of the following procedures?

☐CHEMICAL PEEL Date: _____	☐FACIAL SURGERY Date: _____	☐ BOTOX/DYSPORT Date: _____	☐ LASER HAIR REMOVAL Date: _____
☐DERMAPLANE Date: _____	☐MICRODERMABRASION Date: _____	☐ LASER RESURFACING Date: _____	☐ PHOTOFACIAL Date: _____
☐FACIAL WAXING/SUGARING/THREADING Date: _____		☐ JUVÉDERM/Restylane – List Areas: _____ Date: _____	

Do you have permanent Make-Up? ☐No ☐ Eyebrows ☐Eyeliner ☐Lip Liner ☐Full Lips ☐ Areola Reconstruction

What Concerns do you have regarding your skin?
☐ Fine Lines/Wrinkles ☐ Acne/Acne Damage
☐ Pigmentation ☐ Anti-Aging ☐ Texture/Tone

What areas would you like to treat?
☐ Face ☐ Neck ☐Back ☐Décolleté ☐Other _____

SKIN CARE PATIENTS CONTINUED

List in order of importance the top 3 changes you would like to address with your skin:

1.

2.

3.

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SKIN CARE SENSITIVITY AND PIGMENTATION

Do you have a history of breakouts? ☐ Yes ☐ No	How often do you experience a breakout? ☐ Always ☐ Occasionally (Monthly) ☐ Rarely ☐ Near/During menstrual cycle	What type of breakouts have you had? ☐ Pimples ☐ Blackheads ☐ Pustules ☐ Cysts ☐ Acne Scars ☐ Other:
Do you use tanning beds? ☐ Yes ☐ No	When is the last time you tanned or used a tanning bed? Date: _____	Do you regularly apply sunscreen? ☐ Yes ☐ No
Do you have uneven pigmentation? ☐ Yes ☐ No	How much time do you spend outdoors? ☐ >5 hours ☐ <5 hours ☐ 10+ hours	Do you heal well from a cut? ☐ Yes ☐ No
Is your skin shiny by noon? ☐ Yes ☐ No	Does your skin generally feel oily? ☐ Yes ☐ No	Does your skin feel tight, dry or flakey? ☐ Yes ☐ No

I understand there may be some degree of discomfort (stinging, pinpricking sensation, hotness, or tightness). I understand there are no guarantees as to the result of the skin care treatments, due to many variables including but not limited to: age, condition of skin, sun damage, smoking, climate, etc. I understand I may/may not actually peel, that each case is individual. I understand to achieve maximum results, I may need several treatments. I understand this treatment is for cosmetic purposes and no medical claims are expressed or implied. I understand if I am treating pigmentation concerns, I should refrain from using tanning booths and/or lotions, as it will impede my results. I understand that direct sun exposure is prohibited while I undergo treatment, and the use of sunscreen protection with a minimum of SPF15 is mandatory. I understand that I must wait, at a minimum, 14 days in-between peels, regardless of where the treatment was performed. Although complications are very rare, sometimes they may occur. If I have complications or concerns I need to immediately contact Healthfinity.

If for any reason you are unable to make your scheduled appointment, please contact us within 24 hours of your appointment to cancel or reschedule. Appointments that are not cancelled within 24 hours prior will result in a cancellation fee of $50.00. We understand that some delays are unavoidable but please be aware that if you are 30 minutes late (or later) for your appointment, we will fit you in but you may have to wait or reschedule.

I hereby agree to all of the above, and agree to have this treatment be performed on me. I further agree to follow all post-procedure instructions as directed by my provider. I cannot hold Healthfinity responsible if I do not follow protocol. By signing below, I understand what is expected of me.

_____
Printed Patient Name

_____ ____/_____/_____ _____
Patient Signature Date Witness Signature

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PHOTOGRAPHIC AUTHORIZATION

I understand my photograph and/or video will be taken and is used for medical documentation and demonstration of treatment outcomes. I consent to the taking of those photographs or videotapes of myself or parts of my body in connection with any and all procedures to be performed by Healthfinity.

I understand that these photographs and/or videos may be published by Healthfinity and/or any part acting under Healthfinity's license and authority in any print, visual or electronic media including, but not limited to medical journals, textbooks, scientific presentations, teachings, internet websites, for purposes of informing the medical profession or the general public about any of the procedures, methods, or techniques performed.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that may make my identity recognizable.

I understand I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation. If I do revoke this authorization, it will expire ten (10) years from the date written below.

I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Healthfinity.

I understand the information disclosed, or some portion thereof, may be protected by state laws and/or federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I release and discharge Healthfinity and/or any part acting under Healthfinity's license and authority from all rights that I may have in the photographs, videotapes or case histories and from any claim that I have relating to such use in publication, including any claim for payment in connection with distribution or publication of these materials in any medium.

I grant this consent as voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

_____ ____/_____/_____ _____

Patient Signature Date Witness Signature

SIGN BELOW ONLY IF YOU ARE THE PATIENT'S PARENT, GUARDIAN, OR CONSERVATOR

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

_____ ____/_____/_____ _____

Parent, Guardian or Conservator Signature Date Witness Signature

FINANCIAL POLICY

For all cosmetic patients:

- Cosmetic surgery is not covered by insurance.
- Payments of non-surgical treatments such as Botox, fillers, etc. are due at the time of service. At times, a revision or "touch up" procedure may be desired. Should that be the situation, you the patient, will be responsible for additional fees including but not limited to Operating Room or Anesthesia.
- Payment for procedures may be made in the form of cash, major credit card, cashier's check or one of our financing options. We do not accept personal checks over $1,000.
- A 25% deposit will be made at the time of scheduling.
- All surgical procedures not secured with the initial deposit and not paid for, in full, two weeks pre-op as noted above, will be cancelled without notice.

All Patients: A 1.5% per month service charge will be added to all delinquent accounts. Any account greater than 30 days delinquent may be turned over to a licensed collection agency without notice. Collection fees may range up to 50% of the outstanding balance and is the patient's responsibility.

Cancellations: If for some reason you are unable to make your appointment, please contact us within 24 hours of your scheduled appointment time to cancel or reschedule. Missed appointments/surgical procedures with less than a 24 hour notice of cancellation will be billed to the patient for prompt payment. We understand that some delays are unavoidable but please be aware that if you are 30 minutes late (or later), we will do our best to fit you in but you may have to wait or reschedule.

Cancellation of Other Services:

- Failure to show up to an appointment will result in a $100 fee.
- Cancellations with less than 24 hours before scheduled appointment will result in a $100 fee.

Return Policy: Healthfinity strives to make the best possible recommendations to our patients. If one of our staff members recommends a product you are not satisfied with we will happily exchange the product for another product to meet your expectations.

Contact one of our aestheticians within two (2) weeks of your purchase and schedule a time to return the product. Because our aestheticians are often busy with other clients, an appointment will allow us time to make the best possible recommendation. This will take 10-15 minutes.

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STATEMENT OF FINANCIAL RESPONSIBILITY

I, the undersigned, have read all pages of this document and understand I am responsible for all medical and surgical charges incurred by myself or my dependents. I authorize the release of any medical information necessary to process any claims that are processed on my behalf by Healthfinity. I understand that my medical insurance contract is between my insurance company and myself and that the failure of the insurance company to pay my claim does not absolve my financial responsibility to Healthfinity. All court and attorney fees or other fees associated with the collection of my account are financially my responsibility.

_____ ____/_____/_____ _____

Patient Signature Date Witness Signature

OUR INTERNET & SOCIAL MEDIA POLICY

I understand that Healthfinity desires to protect itself from casual destruction of its online reputation from false unwanted Public Statements made on the internet. Because of healthcare privacy laws such as HIPAA, it is currently very difficult for Healthfinity to protect itself or have the ability to respond to false or unwarranted public statements in the internet.

I understand that if I, the undersigned patient or patient's guardian or conservator, have a genuine complaint about the service or treatment received at Healthfinity, I can:

a) Submit my complaint verbally or in writing directly to Healthfinity, and trust that the complaint will be heard and receive a response; or
b) File a formal complaint with the State Board of Medicine at:

Arizona Medical Board
9545 E Double tree Ranch Rd
Scottsdale, AZ 85258
(480) 551-2700
www.azmed.gov

I understand I must sign this Agreement in order to receive treatment and that by signing and consenting to treatment at Healthfinity, I hereby irrevocably waive ownership of, and convey to Healthfinity all ownership of, all Public Statements made about or concerning Healthfinity, its officers, directors, employees and agents regarding the medical treatment and other services provided by Healthfinity. "Public Statements" shall be defines in this Agreement as all written statements published on the Internet by me or by someone else at my behest or instruction, on any web site that I do not own, or on any social media profile that does not belong or is not controlled by me. Such websites and social media profiles include, but are not limited to, Better Business Bureau web sites, Healthgrades.com, RateMDs.com, Yelp, Yahoo, Google, Facebook, and other review or rating web sites similar in form to any of the above listed sites.

To the extent that I make a Public Statement that Healthfinity, in its sole discretion, deems false or unwarranted, I understand that Healthfinity will use my signature on this Agreement to present to the web site containing the Public Statement, and demand that it be removed. To the extent that any healthcare laws such as HIPAA apply to the Public Statements, I hereby waive the application of such laws for the limited purpose of removing the Public Statement.

Any legal dispute involving this Agreement shall be governed by the laws of Arizona and venue for the dispute shall be exclusively in the courts of Arizona.

_____ ____/_____/_____

Patient Signature Date