Patient Intake Forms – Confidential Information

Demographic Information

Name_____

Home Address_____

City_____State_____Zip_____

E-mail address_____Cell_____

DOB_____Occupation_____

Is it acceptable to leave a message on the above cell number? ☐ Y ☐ N

Is it acceptable to email the above email address? ☐ Y ☐ N

Emergency Contact Name_____

Emergency Contact Phone_____

Primary Care Provider Name_____

Primary Care Provider Phone_____

Primary Care Provider Address_____

City_____State_____Zip_____

Aesthetic Concerns

Are you concerned with facial wrinkles and/or fine lines? ☐ Y ☐ N

Are you concerned with skin laxity (loose skin) and/or lack of volume in your face? ☐ Y ☐ N

Do you feel your face is losing volume and/or appears to be drooping? ☐ Y ☐ N

Do you have a high pain tolerance? ☐ Y ☐ N

Do you have any downtime restrictions? ☐ Y ☐ N

Are you opposed to certain treatment recommendations? ☐ Y ☐ N

What aesthetic treatments have you had in the past?

☐ Botox

☐ Filler

☐ Platelet Rich Plasma or Fibrin

☐ PDO Threads

☐ Face Lift or Other Surgical Intervention

☐ Kybella

☐ Other_____

Was the desired outcome achieved from these treatments? ☐ Y ☐ N

Did you have any adverse reactions or undesirable outcomes? ☐ Y ☐ N

If you answered yes, what was the reaction/outcome?

Your Health

Medical Conditions/Medical History:

Surgical History:

List ALL Medications, supplements and vitamins you take regularly:

List ALL allergies and the type of reaction you have:

Do you smoke? ☐ Y ☐ N Do you use recreational drugs? ☐ Y ☐ N

Weekly alcohol Intake? _____

Daily Water Intake_____

Daily Caffeine Intake (including coffee, tea, soda, chocolate, etc.) _____

Would you rate your diet as ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly (at least 30 minutes 5 days a week? ☐ Y ☐ N

Do you have frequent cold sore outbreaks? ☐ Y ☐ N

If so, how many per year_____

Do you have any history of keloid or hypertrophic scarring? ☐ Y ☐ N

Women: Are you pregnant? ☐ Y ☐ N Nursing? ☐ Y ☐ N

Planning on becoming pregnant? ☐ Y ☐ N

Are you taking oral contraceptives (birth control)? ☐ Y ☐ N

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible.

Please understand full disclosure of any communicable health condition (i.e., COVID19, Flu, conjunctivitis, etc.) is necessary to keep you and our staff healthy. If any of these conditions are present, we will kindly ask you to reschedule your appointment.

I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorder truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Name_____

Patient Signature_____Date_____

Acknowledgement of Practice Policies

I understand that I will receive an aesthetic treatment plan from DG Medical Aesthetics. Some of the treatments we offer include Botox injections, dermal filler injections, and Platelet Rich Plasma Therapy. I understand that each time I present to the office for treatment I will be asked to sign a consent from specific to the treatment I am receiving. _____ (Initial)

I am fully aware that my condition is solely of a cosmetic nature and that the decision to proceed is based on my expressed desire to do so. _____ (Initial)

Payment Policy: I understand that my treatments at DG Medical Aesthetics require payment in full at the time of service and the costs for treatments have been explained to me. The quoted treatment cost is the price for each individual treatment session, unless otherwise specified in writing. I understand that more than one session is often required for optimal outcome. I understand that individual results vary and there are no refunds on treatments received. I understand that services offered by DG Medical Aesthetics are elective in nature and are not covered by my medical insurance. We accept payment in the form of cash, credit or bank check. Personal checks are not accepted. _____ (Initial)

Cancellation Policy: I understand that a valid credit card must be on file to schedule an appointment of any type. I understand that all charges or cancellations must be made at least 48 hours in advance; however, we appreciate notification of changes as far in advance as possible. I acknowledge that any no shows, change or cancellation made less than 48 hours in advance will be charged a fee for the total amount of the scheduled procedure, which will be charged to the credit card on file. Late cancellations or no shows for Botox appointments will be charged a $250 fee. Our services are based on appointments and availability; therefore, missed appointments affect both the patient and provider. _____ (Initial)

Late Policy: DG Medical Aesthetics asks that you arrive at least 5 minutes prior to your scheduled appointment so that all appointments can run SAFELY, efficiently and timely. If I arrive 15 minutes or more past my scheduled appointment time, I understand that my appointment will be canceled and that I will be subject to the fees as outlined above. _____ (Initial)

At DG Medical Aesthetics your safety is our top priority. Rushing through a treatment to accommodate a late arrival poses not only a risk of an undesired aesthetic result but can compromise safety.

Children in Facility Policy: I understand that DG Medical Aesthetics does not offer on-site childcare and for your safety children are not permitted to accompany you to any appointments. Bringing children will forfeit the appointment and will be subject to the fees outlined in the cancellation policy. _____ (Initial)

Return Policy: All skin care sales are final. _____ (Initial)

Disclaimer: I understand that all medial aesthetic treatments are provided exclusively by DG Medical Aesthetics. I will not hold DG Medical Aesthetics, its owners, employees or representatives responsible for the results I experience. I realize that results may vary. I further understand that DG Medical Aesthetics cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion. I understand that even with the best equipment and the highest trained technicians, as high as 10-15% of patients will not have the desired response /outcome to treatments. _____ (Initial)

I have read and fully understand all terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent.

Patient Name: _____

Patient Signature: _____ Date: _____

Services Arbitration Policy

Article 1 Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered will be determined by submission to arbitration as provided by Massachusetts law and not by lawsuit or resort to court process except as Massachusetts law provides for judicial review of arbitration proceedings. Both parties to this contract by entering into it, are giving up their rights to have any such dispute decided in a court of law before a jury; and instead are accepting the use of arbitration.

Article 2 All Claims Must Be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by this provider including any spouse or heirs of the patient and any children, whether born or unborn, at the time of occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herin shall mean both the mother and the mother's expected child or children. All claims for monetary damage exceeding the jurisdictional limit of the small claims court against the provider and the provider's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the provider to collect any fee for the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3 Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators of the appointed parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rate share of the expenses and fees of the neutral arbitrator, together with others expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that arbitrators have the immunity of the judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joiner in this arbitration of any person or entity which would otherwise be a proper additional party in court action and upon such intervention and joiner any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of

Massachusetts law, applicable to health care providers shall apply to disputes within this arbitration agreement. Any party may bring before the arbitrators a motion for summary judgement or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4 General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Massachusetts statute of limitations, or (2) claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herin with reasonable diligence. With respect to any matter not herin expressively provided for, the arbitrator shall be governed by the Massachusetts Code of Civil Procedure provisions relating to arbitration.

Article 5 Retroactive Effect: This agreement covers all services rendered while under the care of the providers of the organization before and after the date that it is signed. Initial_____

I understand that I have the right to receive a copy of this agreement.

Patient Name: _____

Patient Signature_____Date_____

Notice of Privacy Practices

I have been provided an opportunity to review the Notice of Privacy Practices and understand the policy as written. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, or later revoke it, DG Medical Aesthetics may decline to provide treatment to me. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy do occur, DG Medical Aesthetics will provide me a revised Notice of Privacy Practices upon my request.

DG Medical Aesthetics may call my home, cell and other designated locations as documented on intake paperwork and/or scheduling software and can leave a message on voicemail in reference to any items that assist the staff in carrying out treatment, payment or other healthcare operations.

DG Medical Aesthetics may mail to my home or to other designated locations any items that assist in carrying out treatment, payment or other healthcare operations.

Release of Information

I authorize the release of information including diagnosis, records, examination and treatments rendered to me and claims information. This information may be released to:

Spouse_____ Child(ren)_____

Other_____

☐ Information is NOT to be release to anyone

This Release of Information will remain in effect until terminated by me in writing.

Note: Please allow up to 30 days to process your medical records request.

Acknowledgement

By signing this form, I confirm that I received a copy of DG Medical Aesthetics Notice of Privacy Practices. I am consenting to DG Medical Aesthetics use and disclosure of my protected health information to carry out treatment, payment and other healthcare operations.

Patient Name_____

Patient Signature: _____Date: _____

COVID-19 Liability Release Form

Due to COVID-19, we are taking extra precautions with each client and have improved our sanitation and disinfecting practices. Please complete the following and sign below.

_____ I confirm that I, nor anyone in my household have the following symptoms of COVID 19 listed below, nor have had any of the following symptoms in the last 14 days.

- Fever
- Chills
- Cough
- Shortness of breath
- Difficult breathing
- Fatigue
- Muscle aches
- Body Aches
- Headaches
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

To the best of my knowledge, neither I nor anyone in my household has been in contact with anyone who has tested positive for COVID 19. _____ (Initial)

I verify that neither I nor anyone in my household has traveled outside of Massachusetts in the last 14 days. _____ (Initial)

I understand that the CDC recommends social distancing of at least 6 feet, and that is not possible with the service I am receiving today. _____ (Initial)

Patient Name_____

Signature_____ Date_____