2100 Wharton Street- Suite 315
Pittsburgh, PA 15203
20399 Route 19- Suite 120
Cranberry Twp. PA, 16066

412-432-7909

History and Physical

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

*Please provide email address if you wish to receive Skin Beautiful specials.

Date of Birth: _____ Gender: _____

PURPOSE FOR VISIT

☐ Wrinkles/Fine Lines	☐ Acne	☐ Lip Contouring/Thin Lips	☐ Underarm Sweating
☐ Body Contouring/Lipodissolve	☐ Rosacea	☐ Broken Blood Vessels	☐ Stained/Yellow Teeth
☐ Unwanted Hair	☐ Leg Veins	☐ Sun Spots/Age Spots/Birthmarks	☐ Other: _____

Please describe any additional skin goals you may have:

MEDICAL HISTORY

Please list any medical conditions for which you are currently being treated:

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No. If yes, please explain in detail:

Are you currently pregnant or breast feeding? ☐ Yes ☐ No First day of last menstrual period: _____

Do you smoke? ☐ Yes ☐ No

Do you have any tattoos or permanent makeup? ☐ Yes ☐ No

Have you had any of the following:

☐ Cancer	☐ Hepatitis or HIV	☐ Deep Sun Burns	☐ Hyperpigmentation
☐ High Blood Pressure	☐ Herpes (I or II)	☐ Eczema	☐ Keloid (excessive scaring)
☐ Heart Condition	☐ Autoimmune Disease	☐ Psoriasis	☐ Acne
☐ Diabetes	☐ Depression/Anxiety	☐ Rosacea	☐ Dermatitis
☐ Anemia	☐ Menopause	☐ Suspicious Skin Lesions	☐ Vitiligo
☐ Bleeding Disorder	☐ Irregular Menses	☐ Cold Sores	☐ Hives
☐ MS or Myasthena Gravis		☐ Sensitivity to Sunlight	

Are you taking any of the following?

☐ Blood Thinners (including Aspirin)	☐ NSAIDs (Advil, Aleve, Naprosyn)	☐ Antibiotics (Oral or Topical)
☐ Hydroquinone	☐ Vitamin E	☐ St. John's Wart
☐ Retin A/Differin	☐ Antivirals	☐ Gold Therapy
☐ Accutane, Last Treatment	☐ Topical Steroids	☐ Photosensitizing Medications

Please list any other medications you are currently taking, including supplements:

Do you have allergies? ☐ Yes ☐ No. If yes, please explain:

☐ Lidocaine ☐ Antibiotics ☐ Other: _____

☐ Cosmetic Products ☐ Latex ☐ Other: _____

☐ Vicryl ☐ Other: _____ ☐ Other: _____

Have you had any unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks? ☐ Yes ☐ No

Please list any skin treatments you had in the last 12 months (include waxing, electrolysis, laser treatments, peels, etc.):

Have you ever had an adverse reaction to a skin treatment? ☐ Yes ☐ No. If yes, please explain:

Please provide a brief description of your daily skincare routine:

EMERGENCY CONTACT INFORMATION

In case of emergency please fill out the following information:

Name of Contact: _____ Relationship to Self: _____

Emergency Contact's Phone Number: _____

REFERRAL INFORMATION

Primary Care Physician:_____ Office Number: _____

How did you hear about us?

- ☐ Work/Live in Area
- ☐ Skin Beautiful Website
- ☐ Friend or Doctor: _____
- ☐ Walk or Drove Past
- ☐ Google/Other Website: _____
- ☐ Event: _____
- ☐ Mailer: _____
- ☐ Magazine/Newspaper: _____
- ☐ Other: _____

What made you choose Skin Beautiful Medical Spa?

- ☐ Friend or Family Member
- ☐ Providers
- ☐ Price
- ☐ Location
- ☐ Medspa Hours
- ☐ Other: _____

_____ _____

Patient Signature Date

_____ _____

Clinician Signature Date

POLICIES, PROCEDURES, & CONSENTS

Below is an explanation of our policies, procedures, and consent for treatment that will be followed as a patient in our practice. As a patient of our practice you must abide by all of our policies and procedures.

Please review each item:

- I request treatment by The Hormone Center (THC), Skin Beautiful Medical Spa (SBMS) and/or How To Health ("HTH") physician or designee. As a patient, I understand that I have the right to be informed about my condition and the recommended treatment/s including potential benefits and risks so that I can make an informed decision whether or not to undergo the treatment.

- I understand that the Providers at THC/SBMS/HTH, are not my Primary Care Provider (PCP). I understand that I will need a PCP to monitor any ongoing medical problems.

- Some treatments used at THC/SBMS/HTH are considered "off label" use by the Food and Drug Administration. In the United States, the regulations of the FDA permit physicians to prescribe or use approved medications for other than their intended indications. At times, this practice does recommend "off-label use" or "unlabeled uses" for medications. Such uses are not indicative of inappropriate usage but are legal and common. To access for information on off-label uses, please visit the FDA's website: www.fda.gov/eder

- I agree to comply with any pre-treatment, treatment and post treatment instructions as indicated by the physician or her designee. I agree to immediately report any serious adverse reaction or problem to THC/SBMS/HTH.

- I understand that misuse or the failure to follow treatment protocols as prescribed by THC/SBMS/HTH (noncompliance) can result in the dismissal of myself as a patient of the practice.

- I agree to update THC/SMBS/HTH with any demographic or medical health information in a timely manner to avoid disruption of care.

- I agree to schedule office visits at intervals recommended by the provider who reserves the right to withhold refilling of medications if patients do not follow the recommended office visit/appointment schedule.

- To maximize the time with the provider, ARRIVE 15 minutes prior to your appointment to take vitals and complete paperwork. Out of respect for all of our patients' time, if a patient is late the visit may be shortened to accommodate subsequent scheduled patients. Longer appointment times are available with the

provider (please contact our office for details).

- Cancellation policy: If a patient cancels or reschedules within 48 hours of the appointment or fails to keep the appointment, there will be a $75 fee.

- To ensure timely response, questions for all provider between scheduled appointments should be communicated through the clinical staff by phone or through the patient portal.

- Medication refills will be processed in 48-72 business hours from the time of the request. At the time of the request please provide the name, dose, quantity, and pharmacy information to ensure a timely and efficient response.

- Refill requests made after Thursday at 1PM will be received on Monday as the office is closed on Fridays.

- I understand that THC/SBMS/HTH does not accept insurance company payments for possible treatment nor does THC/SBMS/HTH coordinate document submission for potential insurance company reimbursement. Any attempt to be reimbursed by an insurance company is solely the patient's responsibility. Patients will receive itemized invoices with insurance claim codes for possible reimbursement.

- Our providers have opted out of all Medicare/Tricare programs. Therefore, patients are NOT permitted to submit claims to any Medicare or Tricare programs for reimbursement.

- I give my consent for THC/SBMS/HTH to use my photographs for medical documentation/identification purposes.

- Blood draw consent: in the instance that my provider is accidentally exposed to my bodily fluids (i.e., needle stick), I consent to have my blood drawn and tested for HIV and Hepatitis. The results of this testing will remain confidential as required by law.

I have read and understand this consent form and agree to its terms. I understand that payments for procedures at THC/ SBMS/HTH are non-refundable and that it is possible that these procedure treatments may be of little or no help at all. I have had the opportunity to ask any questions about the treatment including: outcomes, risks, complications and alternative therapies. I further understand that THC/SBMS/HTH cannot guarantee the results and will not hold its employees responsible for the individual results of the treatment that I have requested. I also understand that any follow-up treatments required will be at my own expense. This consent form is valid until all or part is revoked in writing.

_____

Patient Name (Printed)

_____ _____

Patient Signature | Date Provider Signature | Date

_____

Relationship to Patient (if another than patient)

HIPAA - PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and discloser of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based on your prior Consent.

The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment, or health
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to the restrictions
- The patient may revoke this consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

I authorize THC/SBMS/HTH staff to discuss my medical care and treatment with the following people:

1._____ 2._____

3._____ 4._____

_____

Printed Name: Patient or Representative

_____ _____

Signature Date

_____

Relationship to Patient (if another than patient)