Advanced Skin Renewal

CLEVELAND'S MEDICAL SPA

Patient Name:_____ Date:_____

DOB:_____ Age:_____ CIRCLE ONE: MALE FEMALE

Address:_____ City:_____

State:_____ Zip:_____ Occupation:_____

Home Phone: _____(_____)_____ Cell Phone:_____(_____)_____

Work Phone: _____(_____)_____ Email:_____

I wish to be contacted in the following manner (Check all that apply).

- ☐ Home Telephone
- ☐ Work Phone
- ☐ Cell Phone
- ☐ Leave a message with a call back number and appointment confirmation only
- ☐ OK to leave a message with detailed information

Additional family members if any, who we may contact: (you receive a $25.00 gift card for every referral that makes a purchase)

Name:_____ Phone: (_____)_____

Name:_____ Phone: (_____)_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Address:_____ Phone: (_____)_____

HOW DID YOU HEAR ABOUT ADVANCED SKIN RENEWAL, LLC? Circle all that apply

Doctor:_____ Friend:_____

Internet Groupon Facebook Instagram

Other:_____

PATIENT IS RESPONSIBLE FOR PROVIDING ANY NESSESARY CHANGES TO THIS FORM

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GENERAL MEDICAL HISTORY

Patient Name:_____ Date:_____

Area of Concern/Reason for Visit? _____

Reason for Consultation? Please Circle all that Apply: Acne Brown Spots/Age Spots Enlarged Pores Fine Lines/Wrinkles Skin Laxity Skin Texture/Scars Unwanted Hair Cellulite Stress Urinary Incontinence Skin Folds Thin Lips Vaginal Rejuvenation Other: _____

How long have you been concerned about the area(s)?_____

At what age did you notice this concern?_____ Are your present skin concerns getting more pronounced? YES NO

Have you ever been treated for this concern? YES NO If yes, what is the concern?_____

If yes, when and what was the treatment method:_____

Are you currently taking medication or using product (serums, cleansers, creams etc.) for your skin concerns? YES NO

If yes, what are you currently using? _____

Are you allergic to any medication? **Yes** **No** **If YES, please specify:**_____

Do you have any other allergies? **Yes** **No** **If YES, please specify:**_____

Current Medication: (Please include any over the counter medications, vitamins, and herbals) _____

_____

Are you currently taking Antibiotics? **Yes** **No**

Preferred Pharmacy Name and Location:_____

PATIENT MEDICAL HISTORY

Do you have not, or have you ever had diseases or conditions of (please circle yes or no):

Skin Cancer	Yes	No	History of STD's	Yes	No	Amyotrophic Lateral Sclerosis	Yes	No
Other Skin Disease	Yes	No	Myasthenia Gravis	Yes	No	Allergies to Bovine (Cow's Milk)	Yes	No
Problems with Skin Healing	Yes	No	Hepatitis	Yes	No	Fainting	Yes	No
Keloid Scars	Yes	No	Eye Disease	Yes	No	Arthritis/Joint Deformity	Yes	No
Skin Rash/ Medications	Yes	No	Autoimmune Disease	Yes	No	Convulsions/Epilepsy	Yes	No
Skin Rash/Bandages	Yes	No	Vision Problems	Yes	No	Gastrointestinal Disorder Lung	Yes	No
Skin Rash/Environment	Yes	No	Numbness	Yes	No	Disease	Yes	No
Skin Rash/Food	Yes	No	Muscle Weakness	Yes	No	Liver Disease	Yes	No
Skin Rash/Other	Yes	No	Multiple Sclerosis	Yes	No	Kidney Disease	Yes	No
Bleeding Problems	Yes	No	Bell's Palsy	Yes	No	Blood Clots	Yes	No
Swelling Hands/Feet	Yes	No	Parkinson's Disease	Yes	No	Phlebitis	Yes	No
Diabetes	Yes	No	Neurological Disorder	Yes	No	Thyroid Problems	Yes	No
High Blood Pressure	Yes	No	Lambert-Eaton Syndrome	Yes	No	Asthma/Wheezing	Yes	No
Chest Pain	Yes	No	Dizzy Spells	Yes	No	Heart Murmur	Yes	No
Irregular Heartbeat	Yes	No	Heart Attack/Pacemaker	Yes	No	Pregnancy spots/mask	Yes	No
Easily Bruise	Yes	No	Heart Disease	Yes	No	Poly-Cystic Ovarian Disease	Yes	No
Hormone Imbalance	Yes	No	HIV/AIDS	Yes	No	Any current anticoagulants or	Yes	No
Abnormal Pap Test	Yes	No				Blood Thinners		

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If yes to any of the above, please explain:_____

Please list any other conditions or disease not listed above:_____

Please list any past hospitalizations:_____

Social History:

Do you smoke? Yes No If yes, how much?_____

Do you drink alcohol? Yes No If yes, how much?_____

Have you ever been exposed to HIV (AIDS) or Hepatitis? Yes No

Family Medical History:

Skin Cancer Yes No If yes Relationship_____Type of Cancer:_____

Other Family Medical Problems?_____Relationship_____

Type of problem:_____

WOMEN ONLY:

Are you pregnant, trying to get pregnant, or lactating/nursing? Yes No

TREATMENT HISTORY:

Are you using Retin-A, Tazerac, Differin, Hydroquinone, or any other topical skin exfoliant or bleaching agent? Yes No

What is it (brand) and how often?_____

Have you ever had plastic surgery to your face or neck areas? Yes No

If yes, please explain:_____

Date of surgery:_____

Have you ever had Botox/Dysport/Xeomin before? Yes No

If so, how long ago?_____ Location of Treatment:_____

Were you happy with this treatment? Yes No

Explain:_____

Have you ever had eyelid/eyebrow droop after Botox/Dysport/Xeomin Yes No

Do you show a lot of upper lid when eyes are open? Yes No

Do your eyelids feel extra heavy when you don't get enough sleep? Yes No

Do your eyelids droop without sleep? Yes No

Special areas of concern for treatment?_____

Have you ever had injectable fillers, collagen, or collagen stimulators before? Yes No

If so, how long ago?_____ Location of Treatment:_____

Were you happy with this treatment? Yes No Explain_____

Special areas of concern of treatment?_____

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Have you ever had laser skin treatments or laser hair removal? Yes No

If yes, what treatment and how long ago?_____

Have you ever used the following hair removal methods in the past month, (please circle all the apply)?

Shaving Waxing Electrolysis Plucking/Tweezing Threading Depilatories

Have you ever had a chemical peel, microdermabrasion, or other skin resurfacing treatment? Yes No

If so, how long ago?_____

Have you ever been treated for pigmented lesions? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you experience hyperpigmentation (redness) from acne, burns, cuts, or insect bites? Yes No

Have you ever had cold sores or fever blisters? Yes No

Skin Types choices (when exposed to the sun for about 1 hour without protection):

Check One

☐ Always burns, never tans ☐ Rarely Burns, Always Tans ☐ Always burns, sometimes tans

☐ Brown Moderately Pigmented Skin ☐ Sometimes burns always tans ☐ Brown or Black Skin

I understand that the information on this foam is essential to determine my medical and cosmetic needs and the provisions of treatment. I understand that if any changes occur to my medical history/health that I am responsible to report this to the office e prior to any treatments. A current medical history is essential for my providers to execute treatment procedures. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omission that I made in the completion of this form.

Patient Signature:_____ **Date:**_____

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SKIN CONSULTS We have an unwavering commitment to making your skin the best it can be. We offer complimentary consultations to access your skin and prescribe a skin care regime specifically tailored to your individual needs.

SCHEDULING - Treatments are by Appointment only. Due to our very full schedule, we suggest you make your appointment at least 3 weeks in advance.

CHECK-IN - Please arrive 10 minutes prior to your scheduled appointment to prepare for your treatment. We require all new clients fill out skin care history and treatment consent forms. For all facial laser treatments, please arrive with a clean face with no make-up. For all laser hair removal treatments please arrive with the area trimmed and shaved.

LATE ARRIVALS - Our scheduling allows the correct amount of time to complete each service. If you are unable to arrive on time for laser, facial, or physician services we will do our best to complete as much of your treatment as possible, however it may be necessary to reschedule. If over 15 minutes late for your scheduled appointment it will be considered a no-show and a $50 charge will result. If you have purchased a series, payment of $50 will be required at your next appointment. We do not refund for treatments used or unused. We have scheduled and pay our staff to be here for your appointment. If you cannot make it, it is your responsibility to compensate their time. Advanced Skin Renewal, LLC will not staff twice to preform your services. Prompt arrival is required for al treatments. Late arrival of more than 15 minutes will be considered a no-show. Forfeiture of any deposits, vouchers, or pre-payments will result. Deposits, vouchers, or pre-payments are considered non-refundable whether paid in person, internet, or over the telephone.

CANCELLATIONS - If you must cancel or change your appointment, please notify us 48 hours in advance to avoid a charge. All services rescheduled, canceled, or missed on same day of appointment are Subject to fees listed above.

PRODUCT RETURNS - Please be well advised about the products you are purchasing. All product sales are final.

CONSIDERATION · This is your time. Please leave babies and children at home. Advanced Skin Renewal is a no cell phone zone, out of courtesy to those around you, please turn off all cell phones and mobile devices

VOUCHER HOLDERS• Voucher holders are held to the same policies as other clients. If you miss your consultations and appointments a $50 charge will be incurred before we will continue treatment. All vouchers are valid for the service for which they were purchased. There is no substitution of services for voucher holders. Vouchers may not be used on retail products.

GRATUITIES - Gratuities are not included in any service or package, but always greatly appreciated.

STANDARD POLICY/NON-REFUNDABLE - Pre-payment is required to secure all physician laser appointments You will be charged a $50 fee for the treatment if you are over 10 minutes late or a 'no show." There are no refunds on and LASER SERVICES, RADIO FREQUENCY SERVICES, OR INJECTABLES, OR WRINKLE RELAXERS.

PREGNANCY• It is unknown if laser surgery may be harmful to an unborn child. I have been advised by my physician to undergo a pregnancy test prior to my procedure. I am declining to submit to such a test and am quite certain that I am not pregnant. I, therefore, waive any claim I may have against Dr. Dominic Haynesworth, independent practitioners, or Advanced Skin Renewal, LLC., should I unexpectedly find myself to be or have been pregnant during my laser treatment

POLICY ON LASER SURGURY "TOUCH UPS"· The cost of your laser procedure is non-refundable. However, if it is determined by you (the patient) or your physician that you need a "touch-up' on the area previously treated, there will be a cost associated with these touch ups. As practitioners, we understand that laser surgery is not an exact science. Tissue response is different for everyone. Therefore, we do not promise that every sunspot will disappear, or that your skin will look like it did when you were 20. It is not possible to remove a lifetime of damage in one treatment. While our results are outstanding, should you desire additional correction, there will be a cost for additional treatments to address your concern. As a patient, I understand that I have the responsibility to follow up through with all post procedure instructions and to keep all appointments, rescheduling when necessary, to ensure optimum results.

POLICY ON KELOIDS, HYPERTROPHIC SCAR FORMATION, BLISTERING, OR SKIN DISCOLORATIONS POST LASER TREATMENT. There are a variety of treatment side effects that are an inherent risk in undergoing in laser treatments. These are outlined within your informed consent and during your consultation. My physician has notified me that I may possibly form keloid; hypertrophic scar tissue that may need excised or treated in order to overcome this problem. I understand that these risks are real and may require additional treatments of procedures to correct. I understand that these side effects can take over a year to subside, and I must be willing and patient to allow for this.

It is advised that if you are someone who will not tolerate a side effect, do not proceed with your laser procedure. We cannot predict who will or will not have a side effect. If side effects occur, all the expenses for such treatments are not included in today's payment.

UNDERTREATMENT AND RESTISTANCE FOR INJECTABLES

There is threshold to which Botox/Dysport/ is effective. Some patients simply are more sensitive than others to the drug's effect.

Every injector experiences patients who return to the office after a toxin injection and report that "My Botox did not work." Some of these patients are adamant and disgruntled and request free re-treatment or refund. This can be an unpleasant situation but easily is prevented by adequate pre- injection discussion and proper informed consent.

It is important for patients to realize that some patients are sensitive to Botox/Dysport/ and some are resistant or immune. It has been theorized that a past subclinical botulinum infection from food poisoning that did not require hospitalization could cause an immunity to botulinum toxin type A. Secondary to that, some patients simply do not respond to any amount of the toxin. This is a rare occurrence among the thousands of patients that have treated at this facility. With respect to all injectable fillers stimulators, your independent provider will make a treatment recommendation to address area(s) of concern. These treatments are also product/usage based. Lack of results due to under-treatment or otherwise may require additional treatments and additional cost. We do not "touch up" fillers free of charge. Touch ups require the purchase of additional product. Your satisfaction of results cannot be guaranteed. Undertreating may result in unpleasant looking results. Recommendations will be made known to you. Injectable Toxins and fillers are product based. If you need a touch up, or if you require more product to obtain results there will be an additional charge.

I read and agree to the above terms for treatments. I understand that I have duty to report any medications, topical skin products, sun exposure, rashes, or skin conditions that may affect treatment outcome. I am to report this prior to each treatment. A current medical history is essential for the caregiver to execute treatment procedures. I certify that I have had an opportunity to read this entire document, that all blanks are filled in before my signing, and that all my questions were answered to my satisfaction. I also certify that I speak, read and write English. My signature below indicates my understanding of any proposed treatments and I hereby give my willing consent to undergo treatment. I understand the terms and I am willing to avoid unnecessary and uncomfortable conversations requesting 'exceptions" to these rules.

Signature: _____ Print Name: _____ Date: _____

Guardian Signature (if minor): _____ Print Name: _____ Date: _____

Witness Signature: _____ Date: _____