THE MED SPA

NORTHWESTERN SPECIALISTS IN PLASTIC SURGERY

MEDSPA INTAKE PACKET

Name: _____ Date: __ __ / __ __ / __ __

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ DOB: __ __ / __ __ / __ __

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Have you ever had any of the following conditions? (check all that apply)

- ○ AIDS
- ○ allergy/hay fever
- ○ anemia
- ○ arthritis/rheumatism
- ○ asthma
- ○ back problems/pain
- ○ bleeding problems
- ○ blood disease
- ○ blood transfusion
- ○ bone or joint pain
- ○ cancer
- ○ chemotherapy
- ○ diabetes
- ○ dizziness/fainting
- ○ drug or alcoholism
- ○ epilepsy
- ○ eye injury or disease
- ○ headaches
- ○ heart disease
- ○ head injury
- ○ hepatitis
- ○ high blood pressure
- ○ infection (active)
- ○ kidney disease
- ○ liver disease
- ○ lupus
- ○ melanoma
- ○ mental disorder
- ○ migraines
- ○ mitral valve prolapse
- ○ nervousness
- ○ radiation treatment
- ○ respiratory problems
- ○ shingles/past outbreak
- ○ shortness of breath
- ○ skin conditions
- ○ sinus problems
- ○ swollen feet/ankles
- ○ stroke
- ○ thyroid problems
- ○ tuberculosis
- ○ ulcers
- ○ varicose veins
- ○ venereal disease

Allergies:

Medications: _____

Cosmetics: _____

Latex/Other: _____

List other diseases/illnesses:

Primary Physician (Name and phone):_____

_____

List recent hospitalizations below:

Year: _____ Reason: _____

Year: _____ Reason: _____

List all current medications/supplements:

_____

_____

_____

_____

_____

Date of last physical: _____

Pharmacy: _____

Location: _____

Phone: _____ Fax: _____

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Patient's Name: _____ Date: __ __ / __ __ / __ __

WHAT MEDICAL AESTHETIC & WELLNESS PROCEDURES ARE YOU INTERESTED IN?

Medical Aesthetic Services:

- Medical Aesthetic Skin Consultation
- Botox®/ Dysport®
- Dermal Fillers (Radiesse®/Juvederm®/ /Sculptra®/Voluma®)
- Laser Hair Removal
- Laser Skin Resurfacing & Rejuvenation
- BBL Photo Facials and Laser Facials
- Microneedling (Micropen®)
- Hydrafacial/ Microdermabrasion
- Chemical Peels & Micropeels
- Medical-grade Facial Treatments
- Skin Care Products

Have you ever had/are currently using:

Retin-A Renova, any retinoic acid	Y	N
Accutane	Y	N
Prescription acne medication	Y	N
Birth control pills/patch	Y	N
Steroids	Y	N
Insulin/Diabetic medications	Y	N
Pregnant/Lactating? Due: _____	Y	N
Cold Sore (<1 yr 1-3 yr 4+ yr)	Y	N
Fever blister (<1 yr 1-3 yr 4+ yr)	Y	N

Previous Cosmetic Facial Treatments:

Chemical peel	Y	N	Date:_____
Botox®	Y	N	Date:_____
Dermal Fillers	Y	N	Date:_____
Tattoo/Perm Makeup	Y	N	Date:_____
Facial Surgery	Y	N	Date:_____
Microdermabrasion	Y	N	Date:_____
Cellulite treatments	Y	N	Date:_____
Laser treatments	Y	N	Date:_____
Tanning (last 2 weeks)	Y	N	Date:_____

Your personal skin Type Evaluation:

Skin Type:	r Normal	r Oily	r Dry	r Combination	r Other
Condition:	r Texture	r Sun Damage	r Acne/Oily	r Pigmented	r Other
Sunburn Sensitivity:	r Always	r Usually	r Occasionally	r Rarely	r Never

Specific areas of concern: _____

_____

Patients Signature: _____ Date:_____

THE MED SPA
NORTHWESTERN SPECIALISTS IN PLASTIC SURGERY

The Med Spa at Northwestern Specialists in Plastic Surgery
CHECK, CANCELLATION & CREDIT CARD FILE POLICY

The Med Spa at Northwestern Specialists in Plastic Surgery accepts the following forms of payment for services and products at our office: Cash, Credit Card (Visa/Mastercard/Discover/American Express), Cashier's Checks, Money Orders, Care Credit, or Debit Cards that have Credit option.

It is our policy to require a **24 hour notice of cancellation** for a scheduled appointment. In the event that you must cancel your appointment with less than a 24 hour notice, we will assess a cancellation fee of **$125** or the cost of the service, whichever is less.

By signing this form, you are agreeing to our cancellation policy and to the cancellation fee for less than 24 hours notice or "no show."

Signature of Patient

Date

676 N. Saint Clair Street | Suite 1575 | Chicago, IL 60611 | 312.266.6240
http://www.northwesternmedspa.com

THE MED SPA

NORTHWESTERN SPECIALISTS IN PLASTIC SURGERY

AUTHORIZATION TO RELEASE AND DISCLOSE PHOTOGRAPHS

This photographic release pertains to photographs taken during the following treatment:

_____

I, _____, voluntarily **consent/decline** (circle one)

the Copyright, publication, and use of my picture and likeness by The Med Spa at NSPS, S.C.; affiliates, successors, and assignees.

By signing this form, I am allowing The Med Spa at NSPS, S.C., affiliates, successors and assignee to disclose photographs taken of me before, during and after treatment.

Please initial either yes or no on each line:

For research, educational informational purposes: Yes: _____ No: _____
For publications in a medical journal and / or textbook: Yes: _____ No: _____
For general advertising, publicity, or promotional purposes: Yes: _____ No: _____

I hereby release The Med Spa at NSPS, S.C. from any claim demand, cause, action, or proceeding of whatever nature arising out of publication and distribution of the said photographs in accordance with the terms of this release. This release also includes affiliates, successors, and assignees of The Med Spa at NSPS, S.C. to disclose photographs of me at any time by sending a letter to Dr. Clark Schierle (or other official representative) telling them not to disclose photographs of me to affiliates, successors, or assignees of The Med Spa at NSPS, S.C. If I send a letter saying that I revoke my authorization, they will agree not disclose any more photographs of me after he or she receives this letter. However, any photographs disclosed prior to his or her receipt of the letter will not be able to be revoked or returned.

I understand that once my photographs have been disclosed to The Med Spa at NSPS, S.C., affiliates, successors and assignees, the photographs will no longer be protected by federal privacy laws. However, The Med Spa at NSPS, S.C., affiliates, successors and assignees will not use the photographs except as permitted on this authorization form. I understand that I will be given a signed copy of this form.

I hereby release The Med Spa at NSPS, S.C.; its affiliates, successors and assignees, from any claim demand, cause, action, or proceeding of whatever nature arising out of publication and distribution of the said photographs in accordance with the terms of the authorization.

_____

Print Name Signature Date

THE MED SPA

NORTHWESTERN SPECIALISTS IN PLASTIC SURGERY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information.
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care ills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinated, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, t a home health agency that provides to care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that our relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of you physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-I sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglects: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Sections 164.500.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing) for the clinic. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you. **Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization Or Opportunity To Object Unless Required By Law**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A **"designated record set"** contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction or your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition the accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request and explanation for you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in the Notice of Privacy Practices.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at this time. Upon you request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Complaints
You may complain to us or to the Office of Civil Rights if you believe your privacy right have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may obtain the address of the OCR Regional Manager, from our privacy officer.

This notice was published and becomes effective on/or before **08/05/2015**.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the form, please ask to speak with our HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient's Name: _____ Date: __ __ / __ __ / __ __