ADVANCED LASER CLINIC
OF MODESTO, A MEDICAL CORPORATION
LASER HAIR REMOVAL | SKIN RENEWAL

General Patient Information Consultant _____

Date: _____ Name: _____

Gender: M F Occupation:_____

Age: _____ Date of Birth: _____

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

Home Phone: _____ Cell Phone: _____

Are you interested in hearing about special offers on services and specials? Yes No

If so please provide your email address _____

How did you hear about our clinic?

_____

Please check the items below that apply to you and your Specific Areas of Interest and Skin Concerns:

	Skincare Products		Microdermabrasion		Chemical Peels
	Facials Acne Treatments		Texture Correction (acne scars, wrinkles, roughness, large pores)		Coloration (dark, age, sun spots)
	Botox		Dermal Filler		Laser Hair Removal
	IPL/Photo facial (sun damage, broken capillaries)		Aerolase LightPod Neo (skin tightening, texture, fine lines, wrinkles, pore size, minor acne scaring)		PRP/Microneedling (texture, pores size, fine lines and wrinkles, skin tightening, acne scaring
	Fibroblast		Cryoskin		

Other: _____

Your current skin care regiment (products being used):

_____

Water (daily intake): 8oz 16oz 32oz 48oz 64oz None

Alcohol (intake): 1 to 2 drinks daily 2-4 weekly Other: _____ None

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Smoking: Do you smoke cigarettes**?** **Circle:** Yes No

Tanning (last 6 weeks): Sun exposure Tanning bed Tanning products None

Hair Removal (last 6 weeks): Plucking Waxing Depilatories Electrolysis Shaving

Patient Signature_____Date_____

Advanced Laser Clinics of Modesto Policies

Please initial acknowledging that you have read and understand clinic policies.

While we make every effort to accommodate our clients, we regret that without at least a 48-hour cancellation notice to reschedule your appointment there will be a minimum **$50.00** fee due. For appointments scheduled for an hour or more a fee of **$125.00** will be due. _____Initials

If you are more than 10 minutes late, we will unfortunately need to reschedule your appointment, which is subject to a $50.00 fee. _____ Initials

There will be a $70.00 fee for all returned checks. _____Initials

Pricing on any of our services is subject to change without notice _____Initials

All packages must be paid for in full prior to scheduling any appointments with a nurse for treatment unless other payment arrangements have been made and approved with the clinic manager. _____ Initials

No refunds will be issued; however, we are happy to transfer a credit to any other service of your choice. All sales are final, and this office is not responsible for any fees incurred in relation to products or services. _____Initials

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Please be aware for liability and safety reasons, children are not permitted in the treatment rooms. The clinic staff is not responsible for child care. Please arrange for child care prior to your appointment, or we will need to reschedule your appointment. Thank you in advance for your cooperation. _____ Initials

Avoid sun (use sunscreen) 2-4 weeks prior to treatment. Tan skin and tanning decreases effectiveness and increases risk of adverse reaction (burns) during laser hair or Skin rejuvenation treatments. _____ Initials

While undergoing laser hair removal treatments, the only option for hair removal is to shave. No waxing, plucking, electrolysis or depilatories. _____ Initials

Please note: All clients are different, and results may vary. If you smoke, results will be limited and may be diminished due to blood circulation. For best results PLEASE stay within your treatment perimeters, and stay well hydrated.

Patient Signature _____Date_____

Please list all previous hospitalizations, surgeries and other procedures with dates

Event	Date	Event	Date

Please list ALL medical conditions and illnesses, including any history facial paralysis

Condition	Date of Onset	Condition	Date of Onset

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Please list all current Medications, Vitamins, Supplements and Skincare Products

Medication Name	Dose/Frequency	Medication Name	Dose/Frequency

Please list all allergies and sensitivities i.e. Hydroquinone, Glycolic acid, Lidocaine

What is your current weight? _____lbs
How tall are you? _____

Are you currently pregnant or breast feeding? Yes No Maybe Not Applicable

Do you bruise or scar (keloid) easily? Yes No. All information is correct _____ Initial

Please list emergency contact name and phone number(s)

Name _____ Phone_____

Name _____ Phone_____

Additional information _____

_____

I certify that the above statements are true and complete to the best of my knowledge. I further understand that any false statements made by me on this form, may be grounds for immediate rejection and/or consideration for further treatment.

Patient Signature **Printed Name** **Date**

_____

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HIPPA PATIENT CONSENT FORM

This consent goes over the HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996. HIPPA, provides information about how we may use and disclose protected health information about you. This Notice contains Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may be subject to change at any given point. If we change our Notice, you may obtain a revised copy by contacting the office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, health care operations, and/or coordination of care.
By signing this form, you consent to our use and disclosure of protected health information about you for the treatment, payment, health care operations, and coordination of care. You have the right to revoke this Consent, in writing signed by you. However, such revocation shall not affect any disclosure we have already made in reliance to your prior Consent. The Practice provides this form to comply with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA).
The Patient understands that:
~Protected health information may be disclosed or used for treatment, payment, health care operations, and-or coordination of care.
~The patient has the right to obtain and view the Notice of Privacy Practices containing a more complete description.
~The Practice reserves the right to change the Notice of Privacy Policies.
~The patient has the right to look over and-or obtain a copy of their records with a signed release.
~The patient has the right to restrict the use of their information.
~The patient may provide a written request to revoke the consent at any time during care.
~If the patient refuses to sign the consent form for purposes of treatment, payment, health care operations, an-or coordination of care, THE PRACTICE HAS THE RIGHT TO REFUSE CARE TO PATIENT.

Patient's Name _____

Patient's Date of Birth _____

Patient's Signature _____

Today's Date _____

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CREDIT CARD AUTHORIZATION FORM

Due to the high volume of patients the Clinic services, providing credit card numbers to comply with Clinic policies is mandatory, if patients refuse to provide the information, services will be denied immediately. The Clinic can also use this account information on file to purchase additional services and gift cards on behalf of the patient for convenience. It is the patient's responsibility to make sure that the account information is maintained as current and valid.

Cardholders Name (as it appears on the card) _____
Credit Card Number (list all numbers) _____
Expiration Date_____
CVV*_____ (3 digits on the back of your card or 4 digits AMX)

Type of card: VISA ___ MASTERCARD ___ AMEX ___ DISCOVER ___
Billing Address_____
City_____ State_____ Zip Code_____

By providing the credit card account information, I agree to be charged the amounts set forth in the "**Cancellation and No-Show Policy" if I fail to comply with terms of the policy.**

Cardholder Signature_____ Date_____