Damn Near Perfect
Laser & Skin Spa
928-889-1870

Client Intake Form

Name: ___________________________________ Date of Birth: __________ Sex:________

Email (Please Print) ____

Address: _________________________________ City: _________________ State: _______

Zip:_________ Home Phone: ________________________Cell: ________________________

Work: _____________ Emergency Contact: ___________________ Phone: ______________

May we send text/email reminders Yes No

May we send text/emails for specials/events Yes No

How did you hear about us? (Please circle all that apply)

Friend Relative Web Google Facebook Instagram *Did a current patient refer you? Y N*

Tell us their name and we will give you and them $25 Referral dollars _____________________

SKIN CARE/What is your daily skin care regimen? __________________________

Which of the following best describes your skin type?

◻ Combination skin (oily in T-zone, dry to normal cheeks) ◻Oily skin ◻Very oily skin, large pores
◻ Sensitive skin ◻ Dry skin

SUN HISTORY & LIFESTYLE

How often do you work outdoors? ◻ Frequently ◻ Occasionally ◻ Very Rarely
How often do you use a sunscreen? ◻ Frequently. ◻ Occasionally ◻ Very Rarely
How often do you use tanning beds? ◻ Frequently ◻ Occasionally ◻ Very Rarely

PREVIOUS PROCEDURES: *Which of the following have you had in the past?*

◻ Botox
◻ Fillers
◻ Chemical Peels
◻ Electrolysis
◻Waxing/Threading
◻ Skin Tightening
◻ Skin Resurfacing
◻ Tattoo Removal
◻ Microdermabrasion
◻ Skin Rejuvenation
◻ Cellulite Circumference Reduction
◻ Laser Hair Removal

INTERESTS: *What would you like to learn more about?*

◻ Fine lines/Wrinkles
◻ Volume Loss/Deep Lines
◻ Skin Care
◻ Age Spots/Sun Damage
◻ Flushing of the Skin
◻ Acne
◻ Acne
◻ Acne Scar Reduction
◻ Large Pores
◻ Crow's Feet
◻ Stretch Marks
◻ Chemical Peels
◻ Laser Hair Removal
◻ Spider Vein Reduction
◻ Skin Texture/Scars
◻ Pigmented Lesions

Reviewed By ____**Date** ________________

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Client____________________________________**DOB** _______________ **Date** __________________

Are you pregnant? Y N Are you nursing? Y N Are you planning on becoming pregnant? Y N

Are you currently taking ACCUTANE or have you taken this in the last 6 months? Y N

Past Personal Medical History (please circle all that apply)

Anemia	Arthritis	Artificial Joint Breast	Bronchitis	Cancer
Bleeding Disorder	Blood Clots	Cancer	Burns	Connective Tissue
Chronic Cough	Cold Sores Depression	Colitis	Diabetes	Disorder
Dialysis	Irregular Heartbeat	Fibromyalgia	Heart Disease	Heart Valve
Heart Murmur	High Blood Pressure	Pacemaker	Defibrillator Migraines	Herpes Simplex
Hepatitis B or	Seizure Disorder	HIV/AIDS	Tuberculosis	Multiple Sclerosis
Phlebitis	Valley Fever	Stroke	Raynaud's Disease	Thyroid Disorder
Ulcers		Metal Implants	Autoimmune Disease	Vitiligo

Past Personal Skin History (please circle all that apply)

Undiagnosed Skin Lesions	Actinic Keratosis	Basal Cell Skin Cancer	Connective Tissue Disorder
Serious Skin Infection	Shingles	Eczema	Squamous Cell Skin Cancer
Melanoma	Lupus Psoriasis	Keloid Scars	Pigment Disorder

Have you ever seen a dermatologist or plastic surgeon for your skin? Y N

If yes, explain: ____

Family History (please circle all that apply)

Adopted	Heart Disease	Stroke	Cancer	Skin Disease	Autoimmune Disorder
Diabetes	Melanoma			High Blood Pressure	

Review of Systems: (please circle) Do you currently have any of the following symptoms:

Poor General Heath	Circulation Problems	Intolerance	Headache	Chest Pain
Swollen Lymph Nodes	Non-Healing Sores	Rashes	Suspicious Moles	Itching
Swollen Legs/Feet	Easy Bruising	Fainting	Bleeding Tendencies	Flushing
		Numbness	Swelling	(Heat/Cold)

Prescription/OTC Medications **Medication Allergy and Reaction**

____

____

Have you or anyone in your family ever had unusual reactions to topical anesthetics (numbing cream)? Y N

Latex Allergy Y N Iodine Allergy Y N

Topical Medications: ☐ Retin A ☐ Renova ☐ Tazora ☐ Refissa ☐ Differen ☐ Other:________________________

Previous Surgeries? ____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client's Signature ______________________**Date**________ **Provider Signature**____________________**Date:** _____

DamnNearPerfectLaser@gmail.com
276 S. Lake Havasu Ave. #A-9-D
Lake Havasu City, AZ 86403

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Client Name ____Date of Birth ____________________

DAMN NEAR PERFECT LASER AND SKIN SPA: APPOINTMENT POLICY & SPA CHECK- IN

A 24-hour notice is REQUIRED for any rescheduling or cancellation of your appointments. If you fail to provide us with a 24-hour notice, a $25.00 fee will be added to your account. By signing below you acknowledge and agree to these terms. Please arrive on time to your appointment to receive numbing cream when necessary and/or to complete any skincare analysis forms, and to relax and enjoy a complimentary beverage. For your comfort, we ask that you shower before any body service.

BEFORE & AFTER PHOTO CONSENT

I am authorizing Damn Near Perfect Laser and Skin Spa and its providers and staff members to take before & after pictures of the procedure(s) that will be performed on me. I understand that these pictures will only be used to determine the optimum outcome of my service and/or treatment. They will not be displayed for any reason.

SPA ETIQUETTE

To provide our guests the best experience, we ask that you please silence your cellphones. To maintain a quiet and relaxing environment.

FINANCIAL AGREEMENT

Payment is due in full at the time of service. Acceptable methods of payment are cash, debit and/or credit card.
I understand that my insurance policy is a contract between myself and my insurance company; Damn Near Perfect Laser and Skin Spa is not involved in billing to your insurance company. If I have questions or concerns regarding my coverage for office visits, procedures, lab work, medications, or conditions, I am responsible for obtaining this information. I agree to pay in full for all services if I choose to have the service provided.

HIPAA

Damn Near Perfect Laser and Skin Spa upholds the standard of the HIPAA laws. As a patient, we want you to know:

- We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy.
- When it is appropriate and necessary, we provide the minimum information to only those in need of your health care information, treatment, payment or health care operations, in order to provide health care that is in your best interest.
- You may refuse to consent to the use or disclosure of your personal health information, but *this must be in writing* Under this law, we have the right to refuse to treat you should you refuse to disclose your Personal Health
- Information (PHI). This information is critical in making appropriate medical decisions.
- If you have any questions regarding this consent, please speak with one of the staff of Damn Near Perfect Laser and Skin Spa

TREATMENT CONSENT AND AUTHORIZATION

I consent to medical screening and medical examination to determine my current health status, other medical evaluations, diagnostic procedures, routine care, and medical treatments which the medical and professional staff of Damn Near Perfect Laser and Skin Spa may deem necessary, advisable, or appropriate. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

My signature here indicates compliance with the above policies and consent.

Client's Signature: _______________________________________ Date: ______________________

Arbitration Form

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 contact were unauthorized or were improperly, negligently or incompetently rendered will be determined by submission to arbitration as provided by state law, and not by a lawsuit or court process, except as therein constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of the 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 provider including any spouse or heirs of the patient and any children whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expectant child. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the provider and its partners, associates, corporation, 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.

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 (30) days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty (30) days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of 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 the arbitrators have the immunity of judicial officers 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 a court action and upon such interaction and any existing court action against such additional person or entity shall be stayed. The parties agree that provisions of state law applicable to health care providers shall apply to disputes with this arbitration agreement. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication. Discovery shall be conducted pursuant to applicable state law; 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 statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by applicable laws relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the provider. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If a patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency surgery) patient should initial below:

Effective as of the date of the first medical services ____________ **Client's Initials**

If any of the provisions of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have a right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: By signing this contract you are agreeing to have any issue of Medical Malpractice decided by a neutral Arbitration and you are giving up your right to a Jury or Court Trial per Article 1 of this Contract.

Print Client's Name ____ **Date** ________________________

Client's Signature ____

Provider Signature ____ *Title* ___Owner______________

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice applies to all records of your care generated and maintained by Damn Near Perfect Laser and Skin Spa.

We are required by law to 1) make sure that medical information that identifies you is kept private; 2) make available to you the notice of our legal and privacy practices with respect to medical information about you; and 3) follow the terms of the Notice that is currently in effect.

How we may use and Disclosed Medical Information about you

We may disclose medical information about you in one or more of the following ways:
To doctors, nurses, or other personnel involved in taking care of you; to people outside the medical group, such as family members, specialists, or others who are in providing services that are part of your care.

For operations, which may include use of information to evaluate the performance of our staff, effectiveness of programs, and ways to improve care and services we offer. These uses and disclosures are necessary to ensure that all our patients receive quality care.

To contact you as a reminder that you have an appointment for treatment or care.

To tell you about or recommend possible treatment options or alternatives, and about health-related benefits, services, events, and activities that may be of interest to you.

To other healthcare providers in the event you need emergency care.
As required by federal, state, or local law.

To a public health organization or federal organization when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

In special situations such as for workers' compensation programs, as required by military command authorities or the Department of Veterans Affairs, in response to a court or administrative order, or for public health activities.
Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may later revoke this permission in writing at any time.

Your Rights Regarding Medical Information about you

You have the right to do any of the following:

To review and receive a copy of medical information that may be used to make decisions about your care.

Usually this includes medical and billing records. You must submit a written request to review and copy your medical information. We may charge a fee for the costs of supplying a copy of the records.

To ask us to amend medical information that you may feel is incorrect or incomplete. Your request for an amendment must be submitted in writing and must provide a reason that supports your request. We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny

Notice of Privacy Practices Cont.

your request if the information: 1) was not created by us; 2) is not part of the medical information kept by or for us; 3) is not part of the information which you are permitted to inspect and copy; or 4) is accurate and complete.

request an "accounting of disclosures." This is a list of disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and include: 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosures to you. You must submit a written request. The request must state a period that may be no longer than six years and may not include dates before April 14, 2003, when current federal health privacy laws became effective.

To request restrictions or limitations on the use or disclosure of medical information about you. You must submit a written request for restriction that specifies: 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply. We reserve the right to refuse your restriction if it conflicts with providing you quality healthcare or in an emergency.

To request that we communicate with you about medical matters in a certain way or at a certain location, such as at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contacted. We will accommodate reasonable requests.

To possess a copy of this Privacy Notice upon request. You may receive a paper copy of this notice at our clinic.

To file a complaint if you believe your rights to privacy have been violated. All complaints must be submitted in writing.

All complaints will be investigated. No personal issue will be raised for filing a complaint.

Changes to this Notice

We reserve the right to change this Notice at any time. We will have available a copy of the current notice at our Spa.

Acknowledgement of Receipt

Notice of Privacy Practices provides information about how we may use and disclose your protected health information. If you would like a copy of the current Notice, please ask a provider or staff member at our office.

I, ____, acknowledge that I have read the Notice of Privacy Practices and understand that I may request a copy of this Notice.

____ ____________________

Signature of Client (or Client's Representative) **Date**

____ ____________________

Printed Name of Client (or Client's Representative) **Relationship to Client**

____ ____________________

Signature of Representative **Date**

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ARIZONA HIPAA MEDICAL RELEASE FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

To comply with the Health Insurance Portability and Accountability Act (HIPAA), we require your written consent to release your medical information to Damn Near Perfect Laser and Skin Spa.

Please read the following information carefully and sign the consent form if you agree to the terms.

from the health records of:

______________________________ Name (Please print first/last name)

________ / ________ /__________ Date of Birth (MM/DD/YY)

(_______)____________________ Phone Number

_____________________________ E-mail Address

____
Street Address City State Zip

I authorize the following persons (or class of persons) to receive my Protected Health Information (PHI):

____
Name (Please print)

____
Street Address City State Zip

(_______)____________________ Phone Number

_____________________________ E-mail Address

DamnNearPerfectLaser@gmail.com
276 S. Lake Havasu Ave. #A-9-D
Lake Havasu City, AZ 86403

INFORMATION TO BE RELEASED (check as applicable)

☐ Allergy Records ☐ Consultations ☐ Developmental/Behavioral ☐ Discharge Summary

☐ Drug/Alcohol Treatment ☐ Genetic Testing ☐ HIV/AIDS

☐ Hospital Records & Reports ☐ Immunizations ☐ Surgical Reports

☐ Prescriptions ☐ Psychiatric ☐ Sexual Assault

☐ Treatment or Tests ☐ X-Ray Reports ☐ Other Communicable Disease ☐ Other (Specify)

-OR–

☐ ENTIRE RECORD excluding the following (CIRCLE as applicable)

☐ Sexually Transmitted Disease ☐ HIV/AIDS ☐ Other Communicable Diseases ☐ Genetic Testing

☐ Developmental/Behavioral Health Care/Psychiatric Care

☐ Treatment of Alcohol and/or Drug Abuse ☐ Information about Child Abuse/Neglect

FOR THE FOLLOWING DATE(S) OF SERVICE

From (MM/DD/YYYY ______ / ______ / _______To (MM/DD/YYYY) ______ / ______ / _______

PURPOSE FOR DISCLOSURE (Check applicable categories)

☐ Treatment ☐ Research ☐ Medical Hardship Waivers

☐ Legal Investigation or Action ☐ Insurance Eligibility/Benefits ☐ Other (Specify):

DamnNearPerfectLaser@gmail.com
276 S. Lake Havasu Ave. #A-9-D
Lake Havasu City, AZ 86403

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above.

I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. However, if my treatment is related to my participation in a research study, I understand that I may be refused treatment if I do not sign this Authorization.

I have read and understood the terms of this Authorization and I have had a chance to ask questions about the use or disclosure of my health information. I authorize the named entity above (page 1) to use or disclose my health information in the manner described above.

SIGNATURE: ___________________________________ DATE: ____________________

Description of Authority to sign if personal/legal representative:

____

IDENTITY OF REQUESTOR VERIFIED VIA:

☐ Photo ID ☐ Matching Signature ☐ Other: _______________

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