



Client Intake Form

Client Information

Name: _____

Full Address: _____

Email: _____

Date of Birth: _____ Cell Phone: _____

Home Phone: _____ Occupation: _____

Emergency Contact Name and Number: _____

How Can We Help You?

What services would you like to learn more about?

Services	<input type="checkbox"/> Dysport/Botox	<input type="checkbox"/> Fillers	<input type="checkbox"/> Kybella	<input type="checkbox"/> Sculptra
	<input type="checkbox"/> Skincare Products	<input type="checkbox"/> Fine Lines/Wrinkles	<input type="checkbox"/> Permanent Makeup	<input type="checkbox"/> Facials
	<input type="checkbox"/> Frown Lines	<input type="checkbox"/> Fullness of Lashes	<input type="checkbox"/> Double Chin	<input type="checkbox"/> Facial Fullness
	<input type="checkbox"/> Face Volume Loss	<input type="checkbox"/> Tattoo Removal	<input type="checkbox"/> Intense Pulsed Light	
	<input type="checkbox"/> Crow's Feet	<input type="checkbox"/> Lip Fullness	<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Facial Veins
	<input type="checkbox"/> Facial Redness	<input type="checkbox"/> Brown Spots/Age Spots	<input type="checkbox"/> Drooping Brow	<input type="checkbox"/> Blotchy Skin
	<input type="checkbox"/> Body Contouring	<input type="checkbox"/> Unwanted Hair	<input type="checkbox"/> Submental Fullness	<input type="checkbox"/> Skin Texture
	<input type="checkbox"/> Face Resurfacing	<input type="checkbox"/> Platelet Rich Plasma	<input type="checkbox"/> Micro-Needling	<input type="checkbox"/> Facial Fullness
	<input type="checkbox"/> Vertical Lip Lines	<input type="checkbox"/> Dark Eye Circles	<input type="checkbox"/> Nasolabial Folds	<input type="checkbox"/> Hair Restoration

How Did You Hear About Us?

Referral Source: (Google, Facebook, Event, etc.) _____

If client referred or employee referred, please list names: _____

Health History – Check all that apply

History

- Accutane
- Pregnant/Lactating
- Retin-A
- Cancerous Lesions
- Cancer
- Metal Pins/Plate
- Epilepsy
- High Blood Pressure
- Taking Blood Thinners
- Diabetes
- Polyphagia
- Herpes
- Trying to get pregnant
- Fainting Spells
- Bleeding Problems
- Pacemaker
- Skin Disease
- Acne
- STD
- Long-term Steroid Use
- Polyuria
- Other _____
- Rosacea
- Hepatitis
- Diabetes
- Auto Immune Disease
- Heart Condition
- Lymphatic Disease
- Melanoma
- Bruise Easily
- Keloid Scarring
- Polydipsia

Currently taking any medication: _____

Food Allergies: Yes No

Allergy to Latex: Yes No

Have you had sun exposure in the last 3 weeks? Yes No

Are you currently pregnant or breastfeeding? Yes No

Med Spa Etiquette

- **Gratuities on services are solely left to client’s discretion. 15-20% is industry standard**
- Children are not allowed in the spa
- No cash refunds. All sales are final Gift certificates are non-refundable and non-redeemable for cash, and must be presented at time of service.
- Gift certificates lost, stolen, or used without authorization are non-refundable, non-replaceable nor valid. All gift certificates expire on date listed on gift certificate.

Cancellations Spa services are extremely popular. While we certainly understand your plans can change, the treatments you select are reserved especially for you. For individual services, a 24 hour cancellation notice is required to avoid being charged a NO SHOW fee of \$75.00. This policy allows others to enjoy our services, as well as recognizing the value of the time of our talented spa technicians. **A NO SHOW will result in a \$75.00 fee being automatically deducted from client’s credit card on file. If a pre-purchased package appt is missed, the result of a no show will be a service being deducted from package.**

Scheduling If arrival is more than 15 minutes after scheduled appointment, the service will be rescheduled as a courtesy to other clients. We recommend scheduling your appointments a minimum of two weeks in advance for the widest selection of services and appointment times. At the time booking, services will need to be secured with a credit card. Visa/MC/AMEX/Discover accepted. Services and prices are subject to change. Please plan to arrive at least 15 minutes prior to your scheduled service to get checked in and prepare for your treatment. Most services require client consultation form to be filled out to enable our technician to better serve you. To avoid delaying our next guests, your service will need to end on time regardless of when you arrived.

Client Signature _____ Date _____

OPEN 6 DAYS A WEEK! Located at 13300 Metcalf Avenue in Overland Park, KS 66213



INJECTIONS

LASERS

ESTHETICS

& MORE!

CALL TODAY! (913) 387-1104 | LEARN MORE! RSVPMEDSPA.COM

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began April 14, 2003. Many of these policies have been our practice for years.

What this is all about: Specifically these rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services.

www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as it is necessary to provide services or to ensure that all administrative matters related to your care are handles appropriately. This specifically includes that sharing of information with other healthcare providers, laboratories; health insurance payers as in necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those records will not be available for persons other than staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you may find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by confidentiality rules of HIPAA>
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.