RSVP Med Spa Client Intake Form

Client Information

Name _____Date_____

Street Address _____City_____State, Zip_____

Email _____

Date of Birth _____ Age _____

Cell Phone _____Home Phone _____

Occupation _____

Emergency Contact Name and Number _____

How Did You Hear About Us? (circle) Google, Facebook, Instagram, Event, Friend_____

Please list friend name if referred by a client (friend will receive $50 credit if you spend $100) _____

How Can We Help You?

Which of our services are you interested in?

- ☐ Botox/Dysport/Jeuveau
- ☐ Longer fuller lashes
- ☐ Sweating
- ☐ Pigmentation/Brown Spots
- ☐ Hair Restoration
- ☐ Laser Hair Removal
- ☐ Facials
- ☐ Dry/Flaky Skin
- ☐ Acne
- ☐ Micro-needling
- ☐ Scarring (Location) _____
- ☐ Dermal Filler
- ☐ PDO Threads
- ☐ Neck Lift
- ☐ Intense Pulsed Light (IPL)
- ☐ Laser Skin Resurfacing
- ☐ Body Contouring/ fat/ muscle
- ☐ Chemical Peels
- ☐ Redness / Rosacea
- ☐ Skincare
- ☐ Sensitivity
- ☐ Sculptra
- ☐ Double Chin
- ☐ Hand Treatment
- ☐ Platelet Rich Plasma (PRP)
- ☐ Exosome (stem cell)
- ☐ VISIA Skin Analysis
- ☐ Oily skin / Large Pores
- ☐ Spider veins face / legs
- ☐ Cosmetic Eyelid Surgery
- ☐ Cellulite reduction

How likely are you to come in monthly for a skin health maintenance or body toning maintenance treatment?

☐ Very Likely ☐ Somewhat Likely ☐ Not at all

Tell us about other services you need and how we can best serve you: _____

_____

Health History

- ☐ Accutane
- ☐ Pregnant/Lactating
- ☐ Rosacea
- ☐ Skin Cancer
- ☐ Cancer
- ☐ Metal Pins/Plate/Implants
- ☐ Epilepsy
- ☐ Hypertension
- ☐ Taking Blood Thinners
- ☐ Diabetes
- ☐ Auto Immune Disease
- ☐ Retin-A, topical retinol
- ☐ Trying to get pregnant
- ☐ Fainting Spells
- ☐ Bruising or Bleeding Issue
- ☐ Pacemaker
- ☐ Skin Disease
- ☐ Acne
- ☐ STD
- ☐ Long-term Steroid Use
- ☐ Thyroid/Endocrine Condition
- ☐ Other_____
- ☐ Herpes / cold sores
- ☐ Liver disease / Hepatitis
- ☐ Anxiety/Depression
- ☐ Kidney Condition
- ☐ Heart Condition
- ☐ Lymphatic Disease
- ☐ Melasma
- ☐ Multiple sclerosis/ ALS
- ☐ Keloid Scarring
- ☐ Hormonal imbalance

Name_____

Surgery including cosmetic surgery _____

_____

Medications including supplements _____

_____

Medication Allergies _____Food Allergies _____

Do you smoke? ○ Yes ○ No Do you drink Alcohol? ○ Yes ○ No Do you use recreational drugs? ○ Yes ○ No

How much? _____

Allergy to Latex	○ Yes ○ No
Are you currently pregnant or breastfeeding?	○ Yes ○ No
Vaccine within 2 weeks or in 2 weeks	○ Yes ○ No
Dental cleaning or work within 2 weeks or in 2 weeks	○ Yes ○ No
Sun exposure or tanning or self-tanning in the last 3 weeks	○ Yes ○ No
Are you taking photosensitizing medications (Accutane, minocycline, doxycycline) in the last 3 weeks?	○ Yes ○ No
Do you use sunscreen daily? SPF_____	○ Yes ○ No
Do you have any tattoos or permanent makeup in the area to be treated? _____	○ Yes ○ No

List skincare and makeup products you use_____

To determine your skin type, please check the one box which best describes your reaction to sun exposure:

____Skin Type I never tans, always burns (extremely fair skin, blonde/ red hair)
____Skin Type II Occasionally tans, usually burns (fair skin, sandy to brown hair, green/brown eyes)
____Skin Type III Often tans, sometimes burn during first exposure to sun (medium skin, brown hair)
____Skin Type IV Always tans, never burns (Olive skin, brown/black hair)
____Skin Type V Never burns (dark brown skin, black hair)
____Skin Type VI Never burns (black skin, black hair)

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.

Cancellation Policy: 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*.

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. However, we will do our best to accommodate you at any time.

Preparation: 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 consent/consultation forms to be filled out.
***A NO SHOW will result in a $75.00 fee being automatically deducted from client's credit card on file.**

Client Signature_____ Date_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides 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 sharing information with other healthcare providers, laboratories, health insurance payers as 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 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.