nourished
MEDSPA AND WELLNESS CENTER

GENERAL CONSENT AND POLICIES

Thank you for choosing Nourished MedSpa and Wellness Center, (herein referred to as the "Clinic"). In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessary to help you fully understand it. This agreement shall serve as perpetual consent along with each and every individual procedural consent form signed by you for services rendered by the Clinic. Adhering to our Clinic policies creates a happy environment where our professionals can focus on your needs.

LATE ARRIVAL
If arrival is delayed, we will make every effort to accommodate your full appointment but service time may be abbreviated to avoid delays for other guests. Abbreviated treatments are charged at full value.

LATE CANCELLATION & MISSED APPOINTMENT
Your appointments are very important to all members of our team at Nourished MedSpa. We do not have a double-booking system so the appointment time is reserved only for you. We understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 24 hours' notice for adjustments to your appointments and for cancellations. All our policies are designed to benefit our guests and to provide the best quality and tradition of excellent service for our established and future clientele. 'No call, no show' or notice which is less than 24 hours in advance, may result in a non-refundable charge per hour of scheduled appointment time. Cancelling or missing two or more appointments may be grounds to require a deposit in order to make any future appointments. Depending on the situation, it may also be grounds for dismissal from the practice. Any deposit paid may be applied to any service or product if the appointment is kept.

I may be charged up to $150 for each hour of scheduled appointment time if I 'no call, no show' or give less than 24 hours' notice for appointment adjustment(s). I will forfeit any deposit(s) if I fail to show up to my appointment. If I subscribe to the membership program, failure to show up to my appointment may be considered completion of the service for that month. I understand that any unused services in my package will not be refunded.

PRICES & PROMOTIONS
We are committed to continuously expanding our services to ensure we bring you the latest and greatest technology. Although we make every effort to keep our website, spa menu and/or flyers updated accordingly, please note that prices, services, offers, specials and products are subject to change at any time without notice. Special offers and discounts may not be combined. When presented with more than one discount opportunity, we will automatically give patients the discount of greater value at the time of purchase.

REFUNDS
Services: We do not offer refunds on services rendered even if you are disappointed in the result or unhappy with the outcome or price. Products: We do not offer refunds on products purchased. Products may be returned for in-store credit within 30 days from the date of purchase when there is a documented allergic reaction to the product. Defective products (i.e., a broken pump) may be exchanged within 7 days from the date of purchase for the same product only. In accordance with federal law, we do not offer refunds or exchanges on prescription products for any reason.

PERSONAL BELONGINGS
Personal belongings are the full responsibility of the spa guest and should be kept in your possession at all times. As a courtesy, we do offer lockers for your belongings, but you retain full responsibility. Nourished MedSpa is not responsible for lost or damaged items.

PROVIDER REQUESTS
We respect your desire to be with a particular treatment provider but we may not always be able to meet special requests due to illness, vacations, and unforeseen schedule changes.

PRACTICE-PATIENT RELATIONSHIP
We love having you as a patient, but we do reserve the right to refuse service at any time, to anyone, for any reason.

OFF LABEL PRESCRIBING
I understand that a physician is not required to use medications as the labeling suggests. This is called off label prescribing and is specifically provided for by the FDA. I understand many of the aesthetic and wellness treatments are considered off-label and I consent to their use. I understand and accept any risks or side effects of off-label medications and treatments, even if they might be serious, for the possible help to, and benefit of, my condition.

FULL DISCLOSURE
I understand that the Clinic will only recommend treatments and procedures that will benefit me specifically and which are medically appropriate for me. I will disclose a full and accurate personal medical history to include any and all information regarding medical conditions and my use of medications, drugs, herbs, vitamins, or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of complications. I am also aware that failure to disclose accurate information about my history may be grounds for dismissal from the Clinic. I am not pregnant, or trying to become pregnant, nor am I breastfeeding at this time.

CONFIDENTIALITY
I understand that per the provisions of the Health Insurance Portability and Accountability Act ("HIPAA") that no information regarding protected health information shall be released to persons not affiliated with the clinic without my express consent except as herein stated and agreed. This prohibition excludes communication between the Clinic and staff members, physicians, pharmacies, labs or diagnostic centers. I understand that any self-publication (including the posting, broadcast or transfer) of any protected health information ("PHI") by myself or others, that reveal or otherwise contain or identify the Clinic and/or any of its agents, any information posted on a blog, review site, internet website, social media or other printed/electronic form or forum, means that my express consent is being given and I am then waiving any privacy protections afforded me under HIPAA, as well as any other applicable

regulations, rules or laws, so to allow the Clinic to respond to, comment on and/or rebut the self-published information. This means that any self-published information, once disclosed, will no longer be protected by HIPAA or the rules promulgated under HIPAA and may then, by my authorization, be disclosed by the Clinic in order to refute or respond to the claims or comments made. I am making this authorization pursuant to HIPAA including 45CFR Sec. 164.508 and understand that any self-publication or disclosure of my PHI authorizes the Clinic and/or any of its agents to respond to the original publication(s) to the extent necessary to defend, limit, comment, and/or challenge the factual assertions contained within such publications. Any and all comments and publications made either under my real name, a moniker, or by others on my behalf will be considered self-disclosed/waived protections of my PHI. This means that I am aware that by disclosing privileged or protected material, I waive my privacy privilege with respect to the subject-matter of the disclosed communication. I consent to, and authorize, my PHI being revealed by the Clinic and/or any of its agents to the extent reasonably necessary to enforce a claim, provide clarification, rebut arguments, defend the reputation and/or establish a defense in a controversy between myself and the Clinic and/or any of its representatives, to a criminal charge, civil claim, dispute, conduct or disciplinary complaint against the Clinic and/or any of its representatives. My authorization will not expire unless I notify the Clinic in writing via USPS return-receipt requested that I revoke this authorization by right. I understand that revocation or failure to sign this authorization may limit or exclude continued treatment by the Clinic.

COST/PAYMENT

Because our practice is limited to elective aesthetic medicine, we do not bill insurance. All prices are subject to change without notice. We accept cash, Visa®, MasterCard®, American Express®, Discover®, Care Credit™, and Nourished MedSpa gift cards. Care Credit™ is a line of credit is between you and the creditor. At your request we can provide you information to apply for CareCredit, but ultimately, this is contract between you and CareCredit. Gift cards may only be used toward any service or product offered at Nourished MedSpa (some restrictions may apply), they are not redeemable for cash or refund. They cannot be replaced if lost or stolen. I understand that there may also be a booking fee for appointments due at the time of scheduling.

I understand that aesthetic procedures are considered "elective" and that payment is my responsibility. My insurance will not be filed. Any expenses which may be incurred by medical care I elect to receive outside of this office, such as, but not limited to dissatisfaction of my treatment outcome, will be my sole financial responsibility. If a touch-up treatment is requested/required, I understand that I will be responsible for the full cost of that additional treatment. I understand that I may request a price quote before treatment. Payment in full for all treatments is required at the time of service and is non-refundable. By paying with a credit card, I hereby certify that I am (1) an authorized user of the credit card, (2) I authorize the Clinic to charge the amount agreed upon to my credit card, and (3) if the charge is declined or reversed by the credit card issuer or network, I agree to pay the Clinic a service charge and to reimburse the Clinic for all reasonable costs of collection. Presenting any form of payment in which I am not an authorized user may be considered fraud and subject to law enforcement notification and prosecution. I understand my information may be saved to file for future transactions on my account. This authorization will remain in effect until I cancel it.

RESULTS

*I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and there can be **no guarantee** as expressed or implied either to the success or other result of treatment. I am aware that full correction is important and that follow-up touch ups/treatments will be needed to maintain the full effects. I am aware that the duration of treatment is dependent on many factors including but not limited to: age, sex, tissue condition, my general health and lifestyle conditions, and sun exposure. Clinical results will vary per patient. The correction, depending on these factors and product used may last 4-6 months and, in some cases, longer. I agree to abide by any and all recommendations made to me in the course of my treatments regardless of inconvenience. I will follow all pre- and post-operative physician instructions carefully; understanding that this is essential for the success of my outcome. I understand that any dietary supplements offered are not intended to treat, diagnose, cure or alleviate the effects of diseases.*

CONSENT

By signing this general informed consent form, I hereby grant authority to Nourished MedSpa and Wellness Center and Dr. Jason Carter, MD (or other delegated medical providers for the Clinic) to perform and/or administer any related treatment as may be deemed necessary or advisable in the diagnosis and treatment of my condition(s). My verbal consent for procedures shall be weighted the same as my written consent. For purposes of advancing medical education, I consent to the admittance of observers to the treatment room and can withdraw this consent at any time verbally. I understand that I have the right to refuse treatment. I agree to adhere to all safety precautions and instructions before and after the treatment. I understand that no refunds will be given for treatments received. No guarantee has been given or implied by anyone as to the results that may be obtained from this treatment. I have read this informed consent and certify that I understand its contents in full. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I certify that if I have any changes occur in my medical history, I will notify the Clinic immediately. I hereby voluntarily consent to elective aesthetic procedures and release the Clinic, medical staff, and all associated professionals from liability associated with the procedure. I understand that the Clinic's services generally consist of ongoing treatments to achieve maximum benefit, and this consent shall apply to all services rendered to me by the Clinic, including ongoing or intermittent treatments. If any part is found deficient, it shall not affect the enforceability of the remainder.

PHOTOGRAPHS

I grant permission to the Clinic, Jason Carter, MD, and agents or employees to take photographs of me for medical purposes to be used for treatment effectiveness, marketing or sales, training, professional publications, and/or case presentations. I understand that they may be used for any medium including print, visual or electronic media including but not limited to: scientific presentations, websites and for purposes of informing the medical profession or general public about the procedures. I understand that I will not be identified by name in any of the published materials and they remain the property of the Clinic. I wave any right to compensation. I understand that I have the right to revoke this authorization in writing at any time. My appearance in or providing statements for videos which may be made for purposes of feedback, recommendations or comments may be used for the purpose of advertising and publicity without restriction.

GUARANTEE

I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs. This agreement is freely and voluntarily executed and shall be binding in perpetuity upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Patient Name (please print)	**Patient Signature**	**Date**

Performed by (please print name and title)	**Practitioner Signature**	**Date**

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MEDSPA AND WELLNESS CENTER

Notice of Privacy Practices

This Notice of Privacy Practices describes how Nourished MedSpa and Wellness Center may use and disclose your protected health/personal information (PHI) to carryout out treatment, payment or business operations (TPO) and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected information. Protected health/personal 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.

Uses and Disclosures of Protected Health/Personal Information

Uses and Disclosures of Protected Health/Personal Information
Your protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you to 1) coordinate medical care, 2) support the business operations of this office, 3) notify a finance company to pay for your care, and 4) any other use required by law. This includes updating, notifying and/or consulting your primary care physician (or other physician whom you have a patient-physician relationship with) on any treatments from any member of this Clinic which have been performed, planned or anticipated.

Treatment: We will use and disclose your protected health/personal information to provide, coordinate, 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/personal information, as necessary, if, as a result of our services, you require treatment by a physician. Your protected health/personal 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/personal information will be used, if requested, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment via electronic means.

We may use or disclose your protected health/personal information in the following situations without your authorization and without notifying you. These situations include: as required by law; public health issues as required by law, communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors and organ donation; research; criminal activity and national security; workers compensation; inmates; required uses and disclosures. Under the law, we must make disclosure to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: The integrity of your protected health information is important to the Clinic. Any self-publication (including the posting, broadcast or transfer) of protected health information (or cause or encourage others to make any such statements), that reveal or otherwise contain or identify the Clinic and/or any of its agents, any information posted on a blog, internet website, review site, or other printed/electronic form or forum, constitutes a waiver of any current or future protections afforded such protected health information under HIPAA, as well as any other applicable regulations, rules or laws. *I understand that any self-publication or disclosure of my protected health information to any entity, public or private, specifically and expressly authorizes the Clinic and/or its agents to respond to my disclosures to the extent necessary to defend, clarify, explain, refute, limit and/or challenge the factual assertions contained within such publications.* Any and all comments and publications made either under your real name or a moniker will be considered self-disclosed/waived protections of your protected health information to the extent such publication is made. By intentionally disclosing privileged or protected material, you waive any privacy privilege with respect to the subject-matter of the disclosed communication. By signing this release, you consent to your protected health information being revealed to the extent reasonably necessary to enforce a claim or establish a defense in a controversy between yourself and the Clinic and/or any of its representatives, to a criminal charge, civil claim, dispute, conduct or disciplinary complaint against the Clinic and/or any of its representatives.

You have the right to inspect and copy your protected health/personal information. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected health/personal information.

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

We are not required to agree to a restriction that you may request. If our medical director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your protected health/personal information will not be restricted. You then have the right to use another service provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to amend your protected health/personal information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health/personal information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw your consent as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **January 1, 2019.** 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/personal information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.

I understand and expressly consent to the above outlined use of my Protected Health/Personal Information being transmitted to the medical director, office staff and others outside the office who are involved in my care and treatment, even if such information is transmitted via non-secure or unencrypted servers, computers, text, phone, fax, voicemail or email.

_____

Patient Name (please print) **Patient Signature** **Date**

Nourished MedSpa and Wellness Center

Patient Information

Date: _____ Name: _____ Date of Birth: _____ Age: _____

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

Preferred telephone number: _____ Home / Work / Cell (circle one) Cell carrier: i.e., ATT/Verizon/Sprint

Ethnicity: _____ E-mail address: _____

Marital Status: Never Married or Single / Married / Divorced or Separated / Domestic Partnership / Widowed

If married, anniversary date: _____ Occupation: _____

Preferred Pharmacy: _____ (please note, no prescriptions will be sent to Kroger in Sherman)

Emergency contact name: _____ Emergency contact number: _____

Emergency contact relationship to you: _____

How did you hear about us? Word of mouth / Internet search / Social Media / Promotion / Other: _____

Referred by: _____Primary care physician: _____

Including your visit today, which of the following issues concern you? (Check all that apply)

☐ Lines/Wrinkles	☐ Aging skin	☐ Spider veins	☐ Acne/breakouts
☐ Hair loss	☐ Unwanted hair	☐ Scars	☐ Deep furrows
☐ Excessive Sweating	☐ Discolored nails	☐ Low energy	☐ Allergies
☐ Double chin	☐ Overweight	☐ Skin tags	☐ Cellulite
☐ Eczema/Rosacea	☐ Skin rejuvenation	☐ Erectile dysfunction	☐ "Gummy smile"
☐ Sun damage	☐ Dull/dry skin	☐ Lip thinness	☐ Excessive oil/shine
☐ Spots or discolorations	☐ Unwanted tattoo(s)	☐ Frown lines	☐ Excess body fat

Other: _____

What procedures interest you either now or sometime in the future? (Check all that apply)

☐ Body shaping	☐ Chemical peel	☐ Botox/Xeomin	☐ Hydrafacial™	☐ Dermal Fillers
☐ IPL Photofacial	☐ Laser hair reduction	☐ Laser tattoo removal	☐ Spider vein / varicose vein removal	
☐ Microneedling	☐ Vampire Facial®	☐ B-12 injections	☐ Hair restoration	☐ Testosterone
☐ PRP Joint injection	☐ Allergy Testing	☐ Weight loss	☐ Female urinary incontinence treatment	
☐ PDO thread facelift	☐ Sexual enhancement	☐ Acne scar treatment	☐ Fat burning injection	
☐ Bioidentical hormone therapy (shots, pellets)	☐ IV fluid/vitamin infusions	☐ Laser Skin resurfacing		

Have you ever had any of the following?

□ Botox/Xeomin/Dysport	□ Microdermabrasion	□ IPL therapy	□ Dermaplaning
□ Chemical peel	□ Dermal fillers	□ Chemical exfoliation	□ Microneedling
□ Laser hair removal	□ Massage	□ Body shaping	□ Laser tattoo removal
□ Laser Skin resurfacing	□ Skin tightening	□ Testosterone replacement	□ B-12 injections
□ Bioidentical hormone therapy		□ IV fluid/vitamin infusions	□ PDO threads placed

When were the above procedures performed and what products were used? _____

_____

In your own words, what would you like to achieve from your treatments?

_____

Have you ever had an allergic reaction to any of the following? (check any box that applies)

	No	Yes, **Mild** (rash, irritation, etc.)	Yes, **Moderate** (itching, vomiting, etc.)	Yes, **Anaphylaxis** (trouble breathing, throat closure, hives, etc.)
Cosmetics				
Food				
Animals				
Sunscreens				
Iodine				
Pollen				
Fragrance				
Shellfish				
Latex				
Medicines/drugs				
Alpha hydroxy acids				
Anesthetics				

Do you smoke? □ Yes □ No How much? _____ packs per day. I quit: □ Days □ Months □ Years ago

Do you drink alcohol? □ Yes □ No □ Daily □ Occasionally □ Rarely

Do you use drugs? □ Yes □ No □ THC

Patient Initial_____

List all medicine drug allergies:

Name	Yes, **Mild** (rash, irritation, etc.)	Yes, **Moderate** (itching, vomiting, etc.)	Yes, **Anaphylaxis** (trouble breathing, throat closure, hives, etc.)

List all medications and supplements (including over-the-counter vitamins, herbals or supplements:

Name and dose	**Schedule**
e.g., Lisinopril 10 mg	*Twice daily*

Please check any medical condition that you currently have or have had in the past:

□ High blood pressure	□ Diabetes	□ Lupus	□ Hepatitis
□ Heart problems	□ Claustrophobia	□ Asthma	□ Eczema
□ Psoriasis	□ Vitiligo	□ Keloids	□ Pacemaker
□ Metal implants	□ Seizures	□ Epilepsy	□ Anxiety
□ Depression	□ Thyroid problems	□ PCOS	□ Permanent makeup
□ Tattoos	□ MS	□ ALS	□ Bell's Palsy
□ Cold sores	□ Shingles	□ Varicose veins	□ Cancer
□ Immunosuppression	□ Poor wound healing	□ HIV	

Other: _____

Please list any and all surgeries:

□ Gall bladder	□ Appendix	□ Uterus removed	□ Ovaries removed
□ Heart	□ Intestines/Colon	□ Breast surgery / implant(s)	□ Ortho (hip, knee, etc..)

Other: _____

Your Skin Care

	0	1	2	3	4
Eye Color	Light blue, light gray or light green	Blue, gray or green	Hazel or light brown	Dark brown	Brownish black
Natural Hair Color	Red or light blonde	Blonde	Dark blonde or light brown	Dark brown	Black
Natural skin color (before sun exposure)	Ivory white	Fair or pale	Fair to beige, with a golden undertone	Olive or light brown	Dark brown or black
How many freckles do you have on unexposed areas of your skin?	Many	Several	A few	Very few	None
How does your skin respond to the sun?	Always burns, blisters and peels	Often burns, blisters and peels	Burns moderately	Burns rarely, if at all	Never burns
Does your skin tan?	Never, I always burn	Seldom	Sometimes	Often	Always
How deeply do you tan?	Not at all or very little	Lightly	Moderately	Deeply	My skin is naturally dark
How sensitive is your face to the sun?	Very sensitive	Sensitive	Normal	Resistant	Very resistant/Never had a problem
Total					

☐ If you scored 0-6 points, you are a **Fitzpatrick Skin Type I**. You always burn and never tan in the sun. You are extremely susceptible to skin damage from the sun.

☐ If you scored 7-12 points, you are a **Type II**. You almost always burn, and rarely tan in the sun. You are highly susceptible to skin damage from the sun.

☐ If you scored 13-18 points, you are a **Type III**. You sometimes burn and sometimes tan in the sun.

☐ If you scored 19-24 points, you are a **Type IV**. You tend to tan easily and are less likely to burn in the sun.

☐ If you scored 25-30 points, you are a **Type V**. You tan easily and rarely burn in the sun.

☐ If you scored 31 or more points, you are a **Type VI**. You do not burn in the sun.**

Note that the closer you are to Type I, the more likely most laser treatments will safely and effectively treat your skin concerns. The closer you are to Type VI, some laser treatments may safely treat your skin concerns, however you may need to pursue other options for your skin type that are non-laser based including highly effective infrared and radio frequency treatments.

*****NOTE: If you have Asian, Native American, Middle Eastern, Latin America or Black ancestry, your skin type is considered Type VI regardless of the above criteria.***

Do you currently use Retin-A, Renova, Hydroquinone, Hydroxyl Acid or Retinol/vitamin A derivative products?

□ Yes □ No Have you used any of the above products in the last 3 months? □ Yes □ No

Have you used an acne medication? □ Yes □ No, if so, when? _____ Type? _____

What skin care products are you currently using? (List brand) _____

Have you recently used any self-tanning lotions, creams or treatments? □ Yes □ No Please specify: _____

Do you wash your face daily? □ Yes □ No Do you exfoliate your skin? □ Yes □ No

Have you used any of the following hair removal methods in the past 4 weeks? *(Please check all that apply)*

□ Shaving □ Waxing □ Electrolysis □ Plucking / Tweezing □ Threading □ Depilatories □ Laser

If yes, where on your body? _____

Acne Questionnaire

How many years have you suffered from acne? _____

Where do you break out? □ Face □ Chest □ Back □ Other _____

What kind of breakouts do you get? □ Blackheads □ Small whiteheads □ Large whiteheads □ Cysts

Do you turn red easily? □ Yes □ No Does your skin become dry easily? □ Yes □ No

Do you blush easily? □ Yes □ No Do you use makeup to conceal your acne? □ Yes □ No

Female Clients Only

Do you menstruate? □ Yes □ No

Are your periods regular? □ Yes □ No

Are you taking contraceptives? □ Yes □ No

Please specify: _____

Any recent changes to or from your contraceptive treatment? □ Yes □ No

If so, what and when: _____

Are you pregnant or trying to become pregnant? □ Yes □ No

Are you lactating? □ Yes □ No

Any menopause problems? □ Yes □ No

Please specify: _____

Are you undergoing any hormone replacement therapy? □ Yes □ No

Please specify: _____

Male Clients Only

Do you wake up with an erection? □ Yes □ No If not, are you concerned about erectile dysfunction? □ Yes □ No

What is your current shaving system? □ Wet shave □ Electric

Do you experience irritation from shaving? □ Yes □ No Ingrown hairs? □ Yes □ No

Is your hair thinning or hairline receding? □ Yes □ No

Are you experiencing symptoms of "male menopause" (i.e., depression, fatigue, weight gain, loss of libido)

□ Yes □ No

Future Appointments/Contact:

May we call or text your preferred phone number to confirm future appointments and send marketing promotions?

Please note standard text messaging rates may apply □ Yes □ No

May we contact you via email to confirm appointments and send marketing promotions?

You may opt out at any time □ Yes □ No

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or complications from my treatment that may be irreversible and/or may be grounds for dismissal from the practice. The treatments I receive here are voluntary and I indemnify and release this institution, all employees and contractors from liability and assume full responsibility thereof.

****Also, please note that we are unable to fill out pre-authorization forms or documentation to your insurance company for prescription medications****

_____ Date: _____

Patient Signature