Laser Wellness of Alabama Family Practice, P. C.
370 St Lukes Drive
Montgomery, AL 36117
334.213.0700

Patient Information

Please complete the following: Date:______________________

Name:____
First Middle Last

Address:____

City:_________________________________ State:_____________ Zip Code:_________________

Date of Birth:______________________________ Driver License Number:___________________________

Home #______________________ Cell #______________________ Work #______________________

Email Address: ____

This gives us permission to contact you regarding products, treatments, and promotions at all of the above methods. If not, please indicate which ones we may use: ____

Emergency Contact Name & Number: ____

How did you hear about us? ____

If through internet search, please tell us what source or words you searched:
____

What is your main reason for visiting our office today?
____
____

Medical History

Please list any known allergies (including medications, food, latex, cosmetics, lidocaine, etc.):
____
____

Please list all medications, including herbal or over the counter, you take on a regular basis, or have taken in the last six months:
____
____

Please list all past surgery operations (including cosmetic/laser procedures):
____
____
____

Your Family Physician: ___________________________________ Date of last exam: ________________

Your Dermatologist:______________________________________ Date of last exam: _________________

	Yes	No	Dates
Insulin Dependent Diabetes	___	___	_______
High Blood Pressure	___	___	_______
Frequent Headaches	___	___	_______
Seizure or Epilepsy Disorder	___	___	_______
Active Skin Disease/Lesions	___	___	_______
Active Infection, Staph Infection	___	___	_______
Cancer	___	___	_______
Blood Clots	___	___	_______
Stroke	___	___	_______
Serious Cardiac Disease	___	___	_______
Bleeding Problems with Cuts, Surgery	___	___	_______
Jaundice or Hepatitis	___	___	_______
Thyroid Disease	___	___	_______
Dizziness, Palpitations, Fainting Spells	___	___	_______
Cold Sores, Mouth Blisters, Fever Blisters	___	___	_______
Weight Change of 10 lbs. in last 6 months	___	___	_______
Psychiatric Disorder	___	___	_______
Arthritis	___	___	_______
Hormone Imbalance	___	___	_______
Herpes	___	___	_______
HIV/Aids	___	___	_______
Keloid Scars	___	___	_______
Skin Cancer/Melanoma	___	___	_______
Vitiligo, Scleroderma, Lupus, Hives	___	___	_______
Tattoos, Permanent Makeup Where? ____________________	___	___	_______
Other	___	___	_______

Please elaborate on any yes answers:

____

____

For our Female clients: Are you pregnant or trying to become pregnant? Yes No
Are you using contraception? Yes No
Are you breastfeeding? Yes No
Are you menopausal or post-menopausal? Yes No
Are you on any type of hormone replacement therapy? Yes No
If yes, please describe:

____

Social History

Do you use Tobacco? ___Yes ___No ___Never How much?______ How long?______
I quit smoking/ use of tobacco as of: ____
How many years have/did you use tobacco: ____
Do you normally have more than 2 drinks of alcohol per day: ____________________________

Sun History

Do you spend a lot of time outdoors? Yes No
Do you ever use a tanning bed? Yes No
Do you currently wear sun protection product all day, every day? Yes No
Have you or any member of your family had skin cancer?_______________________________

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Skin History

Which of the following best describes your skin type? (Please circle 1 skin type):

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin (Hispanic)
VI Black skin

What is your Ethnic Background? ____

Pre Treatment Evaluation

What are your concerns? (Please circle any of the following): Unwanted Hair, Brown/Red Spots, Wrinkles, Lines, Sagging Skin, Acne, Acne Scars, Blemishes, Large Pores, Age Spots, Spider Veins, Fat Reduction
Others (please list):
____

What skincare products are you currently using? (Check all that apply):
___Cleanser, ___ Toner, ___Moisturizer, ___Serum, ___Eye Cream, ___Sunscreen, ___Skin Lightener, ___Vitamin C, ___Retinol, ___Exfoliating Scrubs, ___Masks, ___Self-Tanner
Others (please list):
____

What topical prescriptions have you used? ___RetinA, ___Renova, ___Refissa, ___Adapalene, ____Accutane, ___Hydroquinone 4% In the last 3 months? ___Yes ___No
Others (please list):
____

Have you ever used Accutane? ___Yes, ___No If yes, when did you last use it? ________________

Have you ever had any of the following face treatments?: ___Chemical Peel, ___Laser Resurfacing, ___Dermabrasion, ___Microdermabrasion, ___MicroPen, ___IPL, ___Dermaplaning, ___Face Surgery,
Others (please list):
____

Have you ever been treated with any of the following facial treatments? ___Juvederm, ___Radiesse, ___Belotero, ___Bellafill, ___Botox, ___Xeomin
Others (please list):
____

Do you have hyperpigmentation (dark spots) or hypopigmentation (lightening of the skin) after physical trauma? ___Yes, ___No If Yes, Please describe: ______________________________________

Have you ever had a reaction to any of the following? ___Cosmetics, ___Medicine, ___Iodine, ___Pollen, ___Food, ___Hydroxy Acids, ___Animals, ___Fragrance, ____Sunscreens
Others (please list):
____

What are your skin care goals?
____
____

Patient Signature: ______________________________________ **Date:** ______________________

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CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I Authorize Laser Wellness of Alabama Family Practice, AFP, staff to perform medical treatment. I Consent to AFP use and disclosure of all individually identifiable personal health, financial and demographic information (known as Protected Health Information or PHI) for the purposes of:

- providing medical treatment
- obtaining payment and reimbursement
- requesting healthcare services from other providers
- cooperating with other providers in my medical treatment
- fulfilling requests for information when specifically authorized by me
- and doing all other things directly related to providing healthcare to me

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

The following circumstances may require use or disclosure of your health information.

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of the law enforcement official.
8. For worker's compensation and similar programs.

The above purposes and all other uses are known collectively as Treatment, Payment, and Other Healthcare Operations or TPO.
I have been given the opportunity to review and agree with the terms and conditions of AFP's Patient Information Protection Plan.
I understand my rights to restrict the use and disclosure of PHI and to revoke the consent at any time.
I understand that should I choose not to consent to the terms and conditions of the AFP Patient Information Protection Plan, the practice has the right to and will withhold treatment except where required by law.

I Authorize any physician or heath care facility to provide upon request any PHI to Alabama Family Practice when needed for the purposes of TPO.

I authorize medical information to be given to the following persons: ____________________________________

____

Patient Name: ____

Patient Signature: ____ Date: _____________________________

Insured or Guardian's Signature: ____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protected health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protective health information for non-healthcare related activities without specific and explicit authorization.

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PATIENT INFORMATION PROTECTION PLAN

Our practice is dedicated to maintaining, the privacy of your health information. The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) apply to health information created or maintained by health care providers. The Privacy Rule requires this office to obtain a patient's written consent before using or disclosing the patient's personal health information to carry out treatment, payment, or health care operations (TPO).

Payment refers to the activities undertaken by health care providers to obtain payment or be reimbursed for their service. Common payment activities include, but are not limited to determining eligibility or coverage, billing and collections and authorizing referrals to other providers.

Since use and disclosure of protected health information(PHI) is required in order to provide treatment, payment, or health care operations (TPO); the patient must sign the consent form before his or her first visit. Two exceptions to this rule are in an emergency or when the provider is required by law to treat the individual. A patient's written consent need only be obtained once and may be revoked by the patient in writing.
If the patient refuses to consent, the office will not treat the patient.

It is the policy of this practice not to permit the disclosure of PHI for any non-routine reasons without expressed authorization from the patient. Non-routine disclosures for other than TPO include patient mailing list to third parties and information to an employer for employment decisions. TPO disclosures include disclosures of all pertinent medical information to their health care providers for treatment purposes and to insurers when required to process a claim. The practice must disclose PHI when required by law.

All employees are counseled on the importance of confidentiality. All employees are required to sign an Acknowledgement of Confidentiality. Employees will discuss PHI only to the extent required to carry out TPO. All information is used on a need to know basis and employees access PHI only when required to perform their assigned duties. Others who work near or around medical information but whose job does not require accessing charts will not be allowed access to PHI and business associates will sign privacy protection agreements.

All patients are permitted and encouraged to read this policy and may be provided a copy if they desire.

YOUR RIGHTS REGARDING HEALTH INFORMATION:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests to the best of our ability.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment or operations. Additionally, you have the right to request that we restrict our disclosure to your health information to only certain individuals involved in your care or the payment of your care. We are not required to agree to your request: however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies: or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you. You may submit your request in writing to Laser Wellness 370 St Lukes Drive, Montgomery, AL 36117.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. A reason that supports this request must also be submitted in writing.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy at any time.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. Our privacy officer is Dr. Kathy Lindsey. Please submit any complaints in writing.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by the notice or permitted by applicable law.

If you have any questions regarding this notice please contact Dr. Kathy Lindsey, the privacy officer.

I hereby acknowledge that I have been presented with a copy of Laser Wellness of Alabama Family Practices Privacy Policy. This is the same as AFP.

Patient Name:____

Signature:____ Date:___________________________

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FINANCIAL POLICY

I understand that procedures performed at Laser Wellness, LW of AFP, are cosmetic and not covered by insurance companies. Payment is due at time of service.

I Authorize that payment of medical benefits be made to Laser Wellness of Alabama Family Practice, (AFP), on any claim submitted for services furnished to me by Laser Wellness, AFP and Staff.

I Agree that the fees charged are lawful debts and I promise to pay said fees including the cost of collection at 33.3%, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

I understand that I am financially responsible to LW of AFP for charges.

I understand that LW of AFP's relationship is with me the patient.

I also understand that LW of AFP reserves the right to charge $75.00 fee for appointments not kept. To avoid this they must be cancelled within 24 hours.

I understand that there is a $30.00 returned check fee for every check returned from the bank for insufficient funds.

I understand that accounts more than 90 days past due will be turned over to a collection agency by LW of AFP with or without notice to me and additional fees will be incurred.

I have read, understood and agree to the provisions of this Financial Policy.

Signature of Patient or Responsible Party:____

Date:____