Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of Emergency, Please Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? Internet Facebook Billboard Friend/Relative Other:

Please Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Health Information:

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year? No\_\_\_\_\_ Yes\_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Any recent surgery, including plastic surgery? (past 12 months) No\_\_\_\_ Yes\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) Any skin cancer? No\_\_\_\_ Yes\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) Have you had any piercings, tattoos, or permanent cosmetics? No\_\_\_\_ Yes\_\_\_\_ If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) Have you ever had a body spa treatment before? No\_\_\_ Yes\_\_\_ If yes, What and When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) Has your physician discussed concerns about raising your body temperature? No\_\_\_\_\_ Yes\_\_\_\_\_

 Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidential Client Health History Form** (select all that apply and provide additional information in the space provided on page 3)

\_\_\_\_HIV/AIDS

\_\_\_\_Lupus

\_\_\_\_Metal bone pins or plates \_\_\_\_ Pregnancy, if yes number of weeks \_\_\_

\_\_\_\_Asthma

\_\_\_\_Eczema

\_\_\_\_Epilepsy

\_\_\_\_Seizure disorder

\_\_\_\_Fever blisters

\_\_\_\_Headaches (chronic)

\_\_\_\_Hepatitis

\_\_\_\_Herpes

\_\_\_\_Frequent cold sores

\_\_\_\_Immune disorders

\_\_\_\_Ulcers

\_\_\_\_Cancer

\_\_\_\_Hormone imbalance

\_\_\_\_Systemic disease

\_\_\_\_High blood pressure

\_\_\_\_Spinal injury

\_\_\_\_Thyroid condition

\_\_\_\_Hysterectomy

\_\_\_\_Diabetes

\_\_\_\_Heart problem

\_\_\_\_Varicose veins

\_\_\_\_Arthritis

7) Do you smoke? No\_\_\_\_\_\_ Yes\_\_\_\_\_\_

8) Do you follow a restricted diet? No\_\_\_\_\_ Yes\_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9) Have you had anything to eat today? No\_\_\_\_\_ Yes\_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10) Do you follow a regular exercise program? No\_\_\_\_\_\_ Yes\_\_\_\_\_\_

11) What is your stress level? High\_\_\_\_\_­­\_\_ Medium\_\_\_\_\_­­­­\_\_ Low \_\_\_\_\_\_\_

12) List any medications you take regularly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_

13) List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14) Do you have any metal implants or wear a pacemaker? No\_\_\_\_\_\_ Yes\_\_\_\_\_\_

15) Do you use any of the following? Retin-A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products? No\_\_\_\_ Yes\_\_\_\_\_ Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_

16) Have you used any of these products above in the last 3 months? No\_\_\_\_\_\_ Yes\_\_\_\_\_\_

17) Have you used an acne medication? (Such as Accutane or Isotretinoin) No\_\_ Yes\_\_ Which Drug: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18) Do you form thick or raised scars from cuts or burns? No\_\_\_\_ Yes\_\_\_\_

19) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? No\_\_\_\_\_ Yes\_\_\_\_\_ Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

20) List your daily consumption of: Water \_\_\_\_\_\_\_\_\_\_\_\_\_ Caffeine \_\_\_\_\_\_\_\_\_\_\_\_ Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21) Do you wear contact lenses? No\_\_\_\_\_ Yes\_\_\_\_\_

22) Have you been exposed to the sun or tanning bed in the last 48 hours? No\_\_\_\_\_ Yes\_\_\_\_\_

23) Have you received a spray tan in the past 7 days? No\_\_\_\_\_ Yes\_\_\_\_\_

24) How frequently are you exposed to the sun or tanning bed? \_\_\_\_Infrequently \_\_\_\_Frequently \_­­\_­­\_\_Regularly

25) Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

 Rash Irritation Peeling Sun Sensitivity Breakout

26) Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

 Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs

 Fragrance Shellfish Latex Drugs Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

27) In the last six months have you had:

\_\_\_\_ Resent Injury or Trauma \_\_\_\_ Stroke \_\_\_\_ Acute Joint/ Muscle Injury \_\_\_\_ Abdominal /Inguinal Hernia \_\_\_\_Open Cuts/ Bruises/ Burns \_\_\_\_ Lipoma/ Angioma \_\_\_\_ Dizziness \_\_\_\_ Corticosteroid Treatments \_\_\_\_Raised Moles

\_\_\_\_ A Chemical Peel

\_\_\_\_ Laser Treatment

\_\_\_\_ Facial Injections or Fillers

\_\_\_\_ Infection

\_\_\_\_ Skin Rashes/ Skin Disorders

\_\_\_\_ Inflammation

\_\_\_\_ Blood Thinners

\_\_\_\_ Circulatory/ Heart Conditions

\_\_\_\_ Phlebitis/ Blood Disorder

If you answered yes to any of the above please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand and 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 irritation to the skin from treatments received. I am aware that it is my responsibility to inform the service providers of my current medical or health conditions and to update this history. The treatments received here are voluntary and I release this institution and/or service providers from liability and assume full responsibility thereof.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Female Clients Only:**

28) Are you currently taking any oral contraceptives? No\_\_\_\_ Yes\_\_\_\_ Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

29) Are you pregnant or trying to become pregnant? No\_\_\_\_ Yes\_\_\_\_ If yes, please list any complications below

30) Are you lactating? No\_\_\_\_ Yes\_\_\_\_

31) Any menopause problems? No\_\_\_\_ Yes\_\_\_\_ Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AND CANCELLATION POLICIES**

**Payment for Services Rendered:**

I accept responsibility for the payment of all charges for services rendered to me. I agree to pay all charges for services at the immediate completion of such services.

It may become necessary to release your protected health information to financial parties, credit card entities, banks and financing companies, when requested, to facilitate your payment.

**Cancellation and No-Show Policy:** Time with a service provider is blocked on our schedule for your appointment. We are happy to reschedule all treatments or appointments that are cancelled with advance notice of at least 24 hours. Clients who do not show up for a scheduled treatment or appointment, or who cancel without this notice, will be charged 50% of the total services scheduled that day as a cancellation fee. This will be automatically charged to the credit card we have on file. If we do not have a current credit card on file, the amount will be added to the account balance and must be paid before any additional services are scheduled.

**Product Refunds:** We cannot offer a refund on skincare or other products that have been opened or that are returned unopened more than thirty days after their purchase. We are happy to give you samples of products to try prior to your purchase of a product.

**Credit for Unused Services:** If a client does not tolerate a procedure, we will be happy to offer credit for alternate services equal in value to the services that have been purchased. No cash refunds can be given on unused services and credit for services cannot be used to purchase products. We make no guarantee as to the final result for client’s treatments and we do want to make clients aware that our recommendations regarding number of treatments are only an estimate and to achieve optimal results, additional treatments may be needed. Any unused funds left on patient/client account will be forfeited two years from date of deposit.

**Pre-treatment Instructions:** We reserve the right to cancel and/or reschedule procedures if a client has not followed our pre-treatment instructions (e.g., sun tanning before a laser treatment) and to charge the cancellation fee. This policy is to ensure that our clients have the best possible outcomes from their treatments and reduce the risk of an adverse result.

I have read and understand this Financial and Cancellation Policy for Spa Greystone and agree to comply with this policy.

Client Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Photography Consent**

Consent to take and for the release of

 Photographs/Slides/Videotapes/Medical Records

I hereby authorize Hedden Plastic Surgery and/or Spa Greystone to use all photos including but not limited to pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks, internet, social media sites (Instagram, Facebook, YouTube, Snapchat, etc.), and websites for purposes of medical education, specialty board certification, patient education, lay publication, or during lectures to medical or lay groups.

I understand that I will not be entitled to any monetary payment or any other consideration as a result of any of the images and/or my interview. I also consent for my medical record to be released to a peer physician when necessary for peer chart review.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**