Personal Profile and Health History - Please Print Clearly

Last Name: ________________________________ First: _______________________ Middle: _____________

Street Address: ____

City, State, Zip: ____

Cell Phone: ____________________ Home Phone: ___________________ Work Phone: ___________________

E-mail: ____ Occupation: _________________________________

Date of Birth: _____________________ Age: ______ Height: ________ Weight: ________ Ideal Weight:________

Emergency Contact: _________________________________ Contact Phone: ______________________________

If under 18, person responsible for your account: ____

How did you hear about us? ____

Please specify your genetic origin:

□ African American □ Asian □ Caucasian □ Hispanic □ Mediterranean □ Middle Eastern □ Native American

□ Other (Please Specify) _______________________

Females:

Are you pregnant or breastfeeding? Could you be pregnant? Y N
Are you planning pregnancy during the course of treatment? Y N
During pregnancy did you develop hyperpigmentation or masking? Y N
Do you have regular periods? Y N
Are you going through menopause? Y N

Please list all medications – prescription, over the counter, vitamins, herbs, supplements and reason for taking them:
____
____

Are you taking any blood thinning medications? Y N
Are you allergic to any medications? Y N If yes, please list all medications and reactions:
____
____

Medical History (Please check all that apply)

□ Acne □ High Blood Pressure □ Rosacea □ Bleeding Disorders □ Seizures □ Botox/Dysport /Fillers □ Hormone Replacement Rx □ Shingles □ Burns / Skin grafts □ Implants □ Skin Cancer
□ Diabetes □ Endocrine Disorders □ Keloid Scars □ Thyroid Disease □ Epidermolysis Bullosa □ Lupus Erythematosus □ Vitiligo □ St John's Wort □ Permanent Makeup □ Pacemaker □ Polycystic Ovary Disease □ Cold Sores / Fever Blisters □ Heart Disease □ Port-Wine Stain □ HIV □ Hemorrhoids □ Hepatitis □ Herpes □ Psoriasis □ Accutane □ Menopause □ Low Testosterone

Do you use or consume any of the following? If so, please indicate how much and how often (ex: 3x week / 1x day)

Coffee: ___________ Tea: _________ Soda: _________ Water: _________ Alcohol: _________ Tobacco: _________

Please answer the following questions:

Are you currently being treated for any medical condition? Y N If yes, please explain:

____

Have you been on antibiotics in the last 2 weeks? Y N

Have you had Covid or the Covid vaccine/booster in the past 6 week? Y N

Do you have any active skin diseases or infection in the area being treated? Y N

Do you have any skin allergies? Y N Have you had skin cancer or precancerous lesions? Y N

Do you have psoriasis/eczema in the area to be treated? Y N

Are there any moles in the hair in the area to be treated? Y N

Are you allergic to latex, lidocaine, or any lotions? Y N

Have you had any previous laser treatments/ skin treatments to the area being treated? Y N If yes, please describe:

____

Are you using a prescription Retinoid? (Retin-A, Differin etc) Y N

Are you using glycolic/AHA home care products? Y N

What skin care products are you currently using? ________________________________

Do you or have you ever smoked cigarettes/cigars/vape? Any tobacco use? Y N

Do you sunbathe or use tanning booths? Y N

If yes, approximate date of last sun exposure? __________________________

Are you currently using or have you used a tanning bed or self-tanner? Y N
If yes, approximate date of last use? ______________________________________

Do you use sunscreen? Summer _______ SPF _______ Winter _______ SPF ________ Y N

Do you thread, tweeze, and use depilatories or hot wax? Y N

Does your skin remain discolored after healing from a cut? Y N

Please indicate which of the following concerns you have about your skin?

□ Aged Skin □ Sun Damage □ Rosacea □ Age Spots □ Acne □ Enlarged Pores □ Blackheads □ Texture □ Redness □ Wrinkles □ Whiteheads □ Stretch Marks □ Leg Veins □ Hair Removal □ Oily Skin □ Isolated Fat Areas □ Spider Veins □ Unevenness □ Dry Skin □ Scars □ Scarring □ Hyperpigmentation □ Sensitive Skin □ Melasma □ Dimples □ Cellulite □ Skin Laxity

I confirm that the answers to the questionnaire are true and correct.

____ Date: _______________

Signature of Patient

____ Date: _______________

Signature of Patients Parent/Legal Guardian, if Patient is Under 18

____ Date: _______________

Reviewed by PA-C/NP

Treatment Consent - Please Initial Acknowledging

_____I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied. I understand that to achieve maximum and continued results the protocol recommended by Solace Med Spa should be followed.

_____I understand there are no guarantees implied as to the results of this treatment, due to many variables, such as: age, skin type, skin condition, sun damage, smoking, vaping, alcohol, environmental exposures, etc.

_____I understand that I may or may not actually see demonstrable visible results, that each case is individual.

_____I acknowledge that I have been candid in revealing any condition which might have an effect on this treatment, such as: pregnancy, medication, previous or recent skin surgery or treatment, skin cancer, cold sores/fever blisters, allergies, use of Retin-A, Accutane, Differin or hormones and recent sun/tanning bed exposure.

_____I understand that direct sun exposure, tanning beds, tanning lotions, creams or sprays are prohibited 2 weeks PRIOR to my treatment. The use of sunblock protection with a minimum SPF of 30 is required, along with clothing coverage, over the treatment area(s) 7 days prior to treatment. I agree to refrain from skin tanning/tanning booths while I am undergoing treatment, and during the 14 days following my last treatment.

_____If I am prone to herpetic outbreaks either oral or genital, I have been advised to see my physician for a prescription or will receive a prescription from Solace Med Spa.

_____I agree to refrain from any skin care treatment, cosmetic or medical, 7 days preceding and 7 days following any treatment with Solace Med Spa, including filler injections and Botox/Dysport Cosmetic treatments without discussing with my injector.

_____I understand that I will not be allowed to have any treatments during pregnancy or while nursing. My unused treatments will be placed on hold.

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I consent to the terms of this agreement.

____ Date: ______________
Signature of Patient

____ Date: ______________

Signature of Patients Parent/Legal Guardian, if Patient is Under 18

____ Date: ______________
Solace Med Spa Representative

This form must be completed for all new clients and for continuing clients whose last treatment was 1 year ago more.

Solace Med Spa Cancellation & No Show Policy

When you call to schedule an appointment, the time is blocked off especially for you. During your appointment, we make every effort to run on time and will not allow another person to take your appointment time.

Since these appointments are set aside for you and you only, we require a 24 hour notice of cancellation so we can offer the appointment slot to someone else.We believe this policy allows us to provide the best possible care and customer service for all of our patients. Thank you for your understanding and compliance with this policy.

Failure to provide the required notice will result in a non-cancellation/no show fee that will automatically be charged to the card below

Fees:

A 15 - 30 minute missed appointment will be charged $50
A 1 hour plus appointment will be charged $100

Patient has read and understands the Policy stated above. All questions have been answered to my satisfaction. I authorize Solace Med Spa to charge the above credit card account for payments over to my account for services rendered and/or policies at their office. I agree to update any information regarding this account. The below information is complete and correct to the best of my knowledge

____ Date: ______________
Signature of Patient

____ Date: ______________
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

_______________________________________ _____________________________
Card Holder Name Type of Card Visa/MC/Amex

_______________________________________ _____________ _____________
Credit Card Number Exp Date 3 Digit Code

_______________________________________ _______________________
Cardholder’s Signature Date

HIPAA

In our efforts to comply with the health information privacy act, HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends and co-workers.

Please circle your choice responses to the following questions:

May we leave messages concerning your appointments/treatments on your voicemail? YES NO

May send text messages on your cell phone? YES NO

May we leave messages with a spouse or significant other? YES NO

Name of spouse or significant other: ________________________________

Contact number: ____

Is there anyone that is not listed above that we can give information to? YES NO

If so, please specify.

____

For any children above the age of 18, still living at home, may we discuss
your appointments/treatments with your parent(s) or Guardian? YES NO

Parent or Guardian Name ______________________________________

I would like to receive regular email updates and/or newsletters: YES NO

____
Email address

You must inform us, in writing, of any changes in your directives.
This record will be kept in your file with your acknowledgement of receipt of our Notice of Privacy Practices.

____ Date: _______________
Signature of Patient

____ Date: _______________
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

____ Date: _______________
Solace Med Spa Representative

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN RECEIVE ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY

Solace Med Spa and its employees collect data through a variety of means including but not necessarily limited to intake forms, phone calls, emails, voice mails, and from the submission of our website's contact page.

Information about your financial situation, medical conditions and spa treatments/services that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to intake forms, or directly or indirectly given to us, is held in strictest confidence. We do not give out any information about our patients who receive our treatments and/or services, which is considered patient confidential, is restricted by law, or has been specifically restricted by a patient in a signed HIPAA consent form.

Information is only used as is reasonably necessary to provide you with treatments and/or services which may require communication between Solace Med Spa and health care providers, pharmacies, insurance companies, and other providers.

We are legally obligated to maintain the privacy of your financial situation, medical conditions and spa treatments/services, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to your protected information.

I acknowledge that I have read and understand the information provided to me in the above Notice of Privacy Practices. I feel I have been adequately informed and all of my questions have been addressed and answered to my satisfaction.

____ Date: ______________
Signature of Patient

____ Date: ______________
Signature of Patients Parent/Legal Guardian, if Patient is Under 18

____ Date: ______________
Solace Med Spa Representative