Rockland Med Spa

2 Medical Park Drive, Suite 4
West Nyack, NY 10994

PATIENT INFORMATION

LAST NAME_____FIRST_____ MIDDLE INITIAL_____

HOME ADDRESS_____ CITY_____ STATE _____ ZIP_____

HOME PHONE #_____CELL PHONE #_____WORK PHONE #_____

E-MAIL_____

SEX____M____F AGE_____ BIRTHDATE_____ MARITAL STATUS_____

OCCUPATION_____ CAN WE MAIL INFORMATION TO YOUR HOME: YES_____ NO_____

REASON FOR THIS VISIT_____ DATE_____

WHO REFERRED YOU? _____

Medical History

Are you being treated or have you been treated for any of the following medical problems?

High Blood Pressure	_____	Chest Pain	_____	Heart Attack	_____
Vascular Disease	_____	Asthma	_____	Bronchitis	_____
Abnormal Heart Rhythm	_____	Depression	_____	Vertigo	_____
Thyroid Disease	_____	Anxiety	_____	Diabetes	_____
Kidney Problems	_____	Glaucoma	_____	Cataracts	_____
Ulcers/Gastritis	_____	Tuberculosis	_____	Hepatitis	_____
Diverticulitis/Hiatal Hernia	_____	Epilepsy	_____	Heart Murmur	_____
Persistent cough	_____	Seizures	_____	Herpes	_____
Skin Disease/Disorder	_____	HIV/AIDS	_____	Frequent Cold Sores	_____
Keloid Scarring	_____				

Do you stop bleeding normally? Yes No
Do you have any bad scars? Yes No
Have you ever taken steroids? Yes No
Do you heal normally? Yes No
Have you ever had radiation treatments? Yes No

Please list all current medications & topicals with dosages: None: _____

_____

_____

Height: _____ Weight: _____

Females: Are you pregnant? _____ If no, last menstrual period? _____

Do you smoke? Yes___ #Packs/day_____ No____ Have you recently quit? _____When? _____

Do you drink alcohol on a regular basis? Yes_____ No_____ Occasionally_____

Recreational drug use? Yes_____ No_____

Name of local internist/physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____
Name of Pharmacy: _____ Phone: _____

Address of Pharmacy: _____

AREAS OF INTEREST (Check all that apply)

Surgical Procedures
- ❒ Blepharoplasty (Laser Eyelid Lift)
- ❒ Brow or Forehead Lift
- ❒ Breast Augmentation/Reduction or Lift
- ❒ Chin/Cheek Implants
- ❒ Face or Neck Lift
- ❒ Facial Liposuction (Neck/Jowls)
- ❒ Liposuction
- ❒ Laser Neck Tightening
- ❒ Rhinoplasty
- ❒ Scar Revision
- ❒ SmartLipo (Body Sculpting)
- ❒ Tummy Tuck

Lunch Time Procedures
- ❒ Botox / Dysport / Xeomin
- ❒ Wrinkle Fillers (Injections)
  - Restylane - Perlane
  - Radiesse - Juvederm
- ❒ Liquid Facelift

Other Procedures
- ❒ Mole/Lesion Removal
- ❒ PRP therapy
- ❒ CO2 Resurfacing (Skin Tightening)
- ❒ Sclerotherapy (Leg Veins)
- ❒ Lip Enhancement

Aesthetician Services
- ❒ Skin Care
- ❒ Laser Telangiectasia (Spider veins)
- ❒ Laser Hair Removal
- ❒ Laser (Photo) Facials
- ❒ Microdermabrasion
- ❒ Skin Resurfacing (Laser/Peel/Etc.)
- ❒ Facials (Relaxation/Exfoliation)
- ❒ Microneedling

Please list all previous surgeries & Treatments:

Type of Surgery/Treatment	Place	Year

List all allergies to medications: None: _____

_____
_____
_____

Please list any other medical problems or conditions which you are, or have been treated for:

_____
_____
_____

List all herbal supplements or vitamins that you are taking: None: _____

_____
_____
_____

The above information is accurate to the best of my knowledge:

Signature: _____ Print Name: _____

I understand that payment is required at the time that services are rendered unless other arrangements are made in writing. Services that are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. I will not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise. I agree that this noncredit challenge agreement is irrevocable. I also acknowledge that I have received notification of _____ credentials, training and experience.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Patient Name or Legal Guardian

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PATIENT HIPAA AWARENESS

With my permission, Rockland Med Spa may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Rockland Med Spa Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Rockland Med Spa reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Rockland Med Spa may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Rockland Med Spa may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my permission, the office of Rockland Med Spa may e-mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Rockland Med Spa restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

In addition, by signing this form, I am irrevocably consenting to allow Rockland Med Spa, to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist with payment.

By signing this form, I am allowing Rockland Med Spa to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name or Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (print Patient's name) _____, acknowledge and agree that I have received a copy of our Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to Patient

FOR PRACTICE USE ONLY:

Our facility has made the following good faith efforts to obtain the above-referenced Patient's written acknowledgement of receipt of the Notice of Privacy Practices:

-
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Staff Member **Date**

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.
Examples:

- **Patient was asked to sign upon check-in but refused to do so**
- **Because of medical condition, Patient physically unable to sign acknowledgement**
- **etc.**