PERSONA™
MEDICAL SPA

NEW CLIENT INFORMATION FORM

Date: _____

Please take a moment to complete our client profile. The following information will enable us to recommend the best procedures, therapies and treatments, as well as the appropriate home care products. Any information you provide will be kept confidential.

How were you referred to Persona? □ Gift Certificate □ Google □ Walk-In □ Drive by □ Event □ Email
□ Modern Luxury Magazine □ River Oaks Magazine □ Facebook □ Friend_____

Name: Mrs. / Ms. / Mr. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: (_____)_____ Best Contact number other than cell: (_____)_____

Email: _____ Birthday: _____/____/_____

Sex: MALE / FEMALE Occupation: _____

Emergency Contact Name: _____ Number: (_____)_____

Please list all ALLERIES including LATEX, Medications, Food and other substances:

_____

Are you currently under a doctor's care? □ Yes □ No
Are you currently undergoing any medical treatments? □ Yes □ No
Please list all medications you are currently taking or have taken in the past 6 months, including prescriptions, herbal or over the counter medications.

_____

Do you suffer from claustrophobia? □ Yes □ No Do you have a pacemaker? □ Yes □ No
Stress levels may have an effect on your treatment, would you say your stress level is □ Average □ High

Female Only:
Are you pregnant? □ Yes □ No Please check □ 1st □ 2nd □ 3rd Trimester
Are you breastfeeding? □ Yes □ No

Do you drink Alcohol: □ Yes □ No How often? _____
Do you smoke Cigarettes: □ Yes □ No Packs per day? _____

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Persona's Medical Aesthetic Services-*Please complete so that we may personalize your service for optimal results.*

How many hours a day are you exposed to sunlight (driving, sports, gardening, job etc) : _____

Are you currently using any topical prescriptions? □ Yes □ No If yes, please explain: _____

What skin type do you believe you have? □ Normal-to-Oily □ Normal-to-Dry □ Sensitive/Reactive

Are you using anti-histamine (i.e. Benadryl, Claritin, etc.)? □ Yes □ No

Are you using a vaso-dilator (i.e. Aspirin, Coumadin, etc.)? □ Yes □ No

Have you taken or are using any type of blood thinner (i.e. Aspirin)? □ Yes □ No

Do you have any skin conditions (rosacea/eczema/psoriasis etc.)? □ Yes □ No

Have you ever had an allergic reaction to? □ Cosmetics □ Iodine □ Fragrance

Do you fly frequently? □ More than 1 x month □ Less than 1 x month □ 1 x year

Have you ever had a blood clot? □ Yes □ No

Do you suffer from headaches? If yes, describe: _____

Please circle if you have had any of the following procedures:

□ Plastic Surgery	□ Microdermabrasion	□ Lash/Brow Tinting
□ Skin Pen	□ Filler/Botox Injections	□ Fotofacial
□ Chemical Peels	□ Sclerotherapy	□ Laser Treatments

Persona's Facial & Massage Services- *Please complete so that we may personalize your service for optimal results*

I am concerned with the following condition(s):

□ Blackhead	□ Clogged Pores	□ Skin Laxity	□ Scarring
□ Pore Size	□ Skin Texture	□ Sun Damage	□ Brown Spots
□ Capillaries	□ Uneven Tone	□ Unwanted Hair	□ Redness
□ Whiteheads	□ Anti-Aging	□ Acne	□ Other: _____

Are you currently using Accutane, Retina A, Renova or any other Prescription that may affect the skin? □ Yes □ No

Have you used Accutane in the past 6 months? □ Yes □ No

How often do you exfoliate your skin? □ Never □ Monthly □ Weekly

Check any of the following if used: □ Retina A □ Glycolic Acid □ Hydroquinone □ Renova □ Salicylic Acid

Have you ever or do you currently receive facial treatments? □ Yes □ No

What type of facial massage do you prefer? □ Light □ Medium □ Firm

What type of body massage do you prefer? □ Light □ Medium □ Firm

Do you prefer to have your abdomen massaged? □ Yes □ No

During your facial/massage, do you prefer a heated table? □ Yes □ No

Do you suffer from neck, joint or back problems? If yes, please describe _____

Have you ever suffered a fracture? □ Yes □ No If yes, when and where? _____

Persona's Waxing Service- *Please complete so that we may personalize your service for optimal results*

Is this your first wax treatment? □ Yes □ No

Have you ever had a reaction following a wax treatment? □ Yes □ No If yes, please explain _____

Have you recently exfoliated the area to be waxed (Chemical peels or Acid products)? □ Yes □ No

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CANCELLATION AND RESCHEDULING POLICY

Date: _____

Client: _____

Persona Medical Spa has a 24 hour cancellation, or rescheduling policy. If you miss, cancel or change your appointment with less than a 24 hour notice, you will be charged the following to the credit card on file:

Spa Services – Full Price of your scheduled service will be charged to the credit card on file.

Medical Services- $150 will be charged to the credit card on file.

Persona's Cancellation Policy exists out of respect for the clients as well as our Providers. Cancellations with less than 24 hour notice do not allow other clients the opportunity to schedule an appointment during that time.

By signing below, you acknowledge that you have read and understand the Cancellation/Rescheduling Policy for Persona Medical Spa as described above.

Thank you for your understanding and for your cooperation.

Clients Printed Name: _____

Client Signature:_____Date: _____

Consultant Signature:_____Date: _____

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Your protected health information will be used by Persona Medical Spa or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day to day health care operations of the practice.

NOTICE OF PRIVACY PRACTICES

Persona Medical Spa is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the Notice of Privacy Policies and Practices provided to you.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

You may request a restriction on the use or disclosure of your protected health information. However, Persona Medical Spa may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative if you would like additional information or clarification.
It is a violation of the federal privacy standards if Persona Medical Spa agrees and fails to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Policies and Practices, please consult with a practice representative at the location and contact information listed on the back of the brochure.

YOU MAY REVOKE THIS CONSENT AT ANYTIME

You may revoke this consent at any time; however, Persona Medical Spa requires that you must revoke this request in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the dates of your request.

CHANGES TO PRIVACY PRACTICES

Persona Medical Spa reserves the right to change or modify the privacy practices outlined in the Notice of Privacy Policies and Practices. Persona Medical Spa will notify you of any changes of privacy practices either by mail, at your next appointment or any other pre-approved method that you request.

SIGNATURE

I have reviewed this consent form, received Notice of Privacy Policies and Practices, and given my permission to Persona Medical Spa to use and disclose my health information in accordance with this consent and the notice provided.

PRINT NAME _____ PATIENT SIGNATURE _____

EMPLOYEE AUTHORIZATION _____ DATE _____