# Patient Information & Medical History

## PERSONAL INFORMATION

Today's Date: ________________

**Last Name**: _____________________________________________

**First Name**:_____________________________________________Middle Initial: ___________

Date of Birth:___________________________________Age:___________________ ☐ M / ☐ F

Home Address: ______________________________________________________________________

City:____________________________________________State:_________Zip Code: ______________________

**Home Phone**: (________)___________________________**Cell Phone** :_(________) _______________________

**E-Mail Address**:___________________________________________________(We do not share or sell your information)

Occupation: _________________________________________________________________

**Emergency Contact Information**

Name:__________________________________________
Phone: (________)________________________________
Relationship to you: ________________________________

**Legal Guardian Information (IF PATIENT UNDER 18 YEARS OF AGE)**

Name:__________________________________________
Phone: (________)________________________________
Relationship to you: ________________________________

**How were you referred to us? (Please check one):**

- ☐ Friend: Name:____________________________May we contact them Y N
- ☐ Internet Website: ☐Google ☐Yahoo ☐CitySearch
- ☐ Walking/ Driving By
- ☐ Other (Please Specify): __________________________________________________________

**TREATMENT REQUESTED (please circle)**

☐ Botox
☐ Dermal Fillers
*Allergan Products, Restylane, Radiesse
☐ Microdermabrasion
☐ Morpheus 8 Fractional treatment
☐ Chemical Peels
☐ Cellulite Reduction
☐ Acne Scars
☐ Pigmentation/Brown Spots/Sun Damage
☐ Wrinkle Reduction
Fat Reduction
Skin Tightening

☐ PRP
☐ Micro Needling
☐ Non-Surgical Lift
☐ Body Contouring
☐ Emsculpt
☐ Fat Extraction for Stem Cell Therapy
☐ Hyperhidrosis
☐ Spider Vein Therapy
☐ Laser Hair Reduction
☐ Laser Skin Rejuvenation
Other: ______________________

**May we contact you about our Savings & Promotions via email, voice mail, or text: Y N**

## MEDICAL HISTORY

Are you currently under the care of a physician? ☐YES ☐ NO

If yes, for what:______________________________________________________________

______________________________________________________________

Are you currently under the care of a dermatologist ☐YES ☐ NO

If yes, for what:______________________________________________________________

______________________________________________________________

Do you have a history of erythema Ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat? ☐YES ☐ NO

**Tobacco: Y N Amount:___________** **Coffee/Tea/Soda: Y N Amount:___________**

**Alcohol: Y N Amount: ___________** **Daily Exercise: Y N Amount: ___________**

**Medications, Vitamins, Herbs or Ointments:______________________________________________**

______________________________________________________________

**Please list all ALLERGIES including LATEX, Medications, Food and other substances: ______________________**

**Regular Aspirin Use: Y N** **Ibuprofen (Motrin, Advil): Y N**

**Medication Allergy: Y N** **Name & Reaction________________________________**

**Latex Allergy Y N** **Source & Reaction________________________________**

**Tape Allergy: Y N** **Type & Reaction: ________________________________**

| | | | |
|---|---|---|---|
| **Abnormal Bleeding: Y N** | **Cancer: Y N** | **Hepatitis: Y N** | **Reflux/Heartburn: Y N** |
| **Autoimmune Disease: Y N** | **C.O.P.D: Y N** | **Eczema: Y N** | **Stroke History: Y N** |
| **Polycystic Ovaries: Y N** | **Fibroids: Y N** | **Psoriasis: Y N** | **Polycythemia vera: Y N** |
| **Diabetes: Y N** | **Anemia: Y N** | **Fainting Spells: Y N** | **High Blood Pressure: Y N** |
| **Asthma: Y N** | **Seizures: Y N** | **Cardiac/Disease: Y N** | **Mitral Valve Prolapse: Y N** |
| **Blood Clots: Y N** | **Sleep Apnea: Y N** | **HIV/Aids: Y N** | **Blood Transfusion: Y N** |

**History of Cold Sores: Y N**

Please describe all **"YES"** responses: ______________________________________________

______________________________________________________________

Have you had any recent tanning, use of self-tanning lotions, or sun exposure that changed the color of your skin?
☐YES ☐ NO

Do you form thick or raised scars? ☐YES ☐ NO

Do you have Hyper Pigmentation (darkening of the skin) or Hypo Pigmentation (lightening of the skin) or marks after physical trauma? YES ☐ NO ☐ If yes, please describe:

______________________________________________________________

**FOR ALL PATIENTS:**

*I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the practitioner to execute appropriate treatment procedures.*

Print Name:______________________________Signature:_________________________Date:

**HISTORY & PHYSICAL AESTHETIC EXAM**

Client Name:___________________________________ Date: __________________

I understand that PERSONA and their Providers are performing services for me that are related specifically and only to the cosmetic improvement of my appearance which may include aesthetic equipment, technology and products to deliver the following treatments as needed for my goals: Neurotoxin and Nutrient injectables, Dermal fillers, Body contouring, Laser therapy, Radiofrequency, Intense Pulsed Light, LED, Skin and Muscle tightening/toning, Ultrasound therapy, Electromagnetic field therapy, Suture threads, IV nutrients by a certified and or licensed professional. PERSONA is a medical aesthetics practice and not a dermatology or plastic surgery practice. The examination does not represent a complete history and physical examination for any other area of medical practice and relates to cosmetic/ aesthetic services and treatments performed at PERSONA MED SPA.

Client Signature:________________________________ Date: __________________

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PROVIDER USE ONLY

**Chief Complaint**: ______________________________________________________________

**Relative past medical history**:

____________________________________________________________________________________

____________________________________________________

- ☐ Intake form reviewed
- ☐ Client is not taking contraindicated medications
- ☐ Client is not pregnant or breastfeeding. LMP: ______________________
- ☐ Client has not experienced prolonged exposure to the sun within the last two weeks without use of sun block
- ☐ Client has not been on Accutane within the previous 6 months

**Limited Physical Examination**: Vital signs: Temp: ______ B/P: ______ HT: ______ WT: ______

____________________________________________________________________________________

____________________________________________________________________________________

**Impression**:

- ☐ Unwanted or Thinning hair: __________________________________________
- ☐ Pigmented lesion: _______________________________________________
- ☐ Vascular lesion: ________________________________________________
- ☐ Facial Rhytides,laxity or loss of volume: _______________________________
- ☐ Other:____________________________________________________

**Plan**:

Client is an appropriate candidate for any of the following treatments to address concerns and aesthetic goals.

- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

Laser Rejuvenation
Coolsculpting

IPL Photofacial
Photofacial

Dermal Fillers
*Allergan Products, Restylane, Radiesse

Other:
______________

Neurotoxin Injection
*Botox, Dysport

Ultherapy
Laser Hair Removal

Microneedling
Hair Restoration

Emsculpt
Morpheus

Exilis-Face
Exilis-Body

Emsella
Thread Lift

**Recommendation**______________________________________________________________________________

______________________________________________________________________________________________

Provider Signature_________________________________________________________________Date_______________________

# Persona Med Spa

## CANCELLATION POLICY

At PERSONA Med Spa we strive to deliver an excellent experience and the best service possible. In order to achieve this, we are conscientious of everyone's time and availability, therefore, we require at least a 24hour notice when you cannot keep your appointment time. We want to give every client ample opportunity to benefit from appointments as they become available.

It is the policy of PERSONA Med Spa to charge for any scheduled appointment cancelled less than 24 hours before the appointment time or a client who does not show for a scheduled appointment.

Medical Aesthetic services: Cancellation fee $150.00 ______Initial
Spa Services: Cancellation fees consist of the full service fee. ______ Initial

**ACKNOWLEDGMENT**:

By signing below, I acknowledge PERSONA Med Spa's no show/cancellation policy. I understand that if I fail to comply with the no show/cancellation policy, I will be charged the stated fee above for my service

I understand that if I decline to pay the fee, and I have purchased a package; a treatment will be deducted from my treatment package.
________ (Initial)

I understand all sales & deposits are final & non-refundable.

________ (Initial)

Client Signature _________________________Print Name_______________________ Date ________

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:**

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, training of medical students, licensing, contacting, or arranging for other business activities. We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

**Appointment Reminders**

We may contact you to provide appointment reminders.

**Treatment Information**

We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Disclosure to Department of Health and Human Services**

We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation of determination of our compliance with relevant laws.

**Family and Friends**

Unless you object, we may disclose your medical information to family members, other relatives, or close personal friends when the medical information is directly relevant to that person's involvement with your care.

**Notification**

Unless you object, we may use or disclose your medical information to notify a family member, a personal representative, or another person responsible for your care of your location, general condition, or death.

**Disaster Relief**

We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose Of coordinating with that entity to assist in disaster relief efforts.

**Health Oversight Activities**

We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure, or disciplinary actions, administrative and/or legal proceedings.

**Abuse or Neglect**

We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

**Legal Proceedings**

We may disclose your medical information in the course of certain judicial or administrative proceedings.

**Law Enforcement**

We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

**Coroners, Medical Examiners, and Funeral Directors**

We may disclose your medical information to a coroner, medical examiner, or a funeral director.

**Organ Donation** If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

**Research**

We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.

**Public Safety**

We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

**Worker's Compensation**
We may disclose your medical information as authorized by laws relating to worker's compensation or similar programs.
**Business Associates**
We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.
**AUTHORIZATIONS:**
We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Stanley C. Jones M.D.
PERSONA Med Spa
2311 West Alabama Street
Houston, Texas 77098
713-630-0772

**YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:**
You have the following rights with respect to your medical information:
You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
You have the right to receive communications from us in a confidential manner.
Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
You have the right to receive an accounting of the of the disclosures of your medical information made by our practice during the last six years (or following August 1, 2014) except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.
You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact: Stanley C. Jones M.D.

Stanley C. Jones M.D.
PERSONA Med Spa
2311 West Alabama Street
Houston, Texas 77098
713-630-0772

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

US Department of Health and Human Services 200
Independence Ave. SW
Washington, DC 20201
**THIS NOTICE IS EFFECTIVE AS OF March 5th, 2010.**

**REVISION OF NOTICE OF PRIVACY PRACTICES**
We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request.

Acknowledgment of Receipt of Privacy Notice

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

______________________________________

Print Name of Patient or Legal Representative

______________________________________

Signature of Patient (or Legal Representative)

______________________________________

Date

______________________________________

Signature of Employee

______________________________________

Title of Employee / Date