Patient Information
Drops of Beauty Anti-Aging Medical Spa

Last Name:_____ First Name:_____ M.I._____.

Date of Birth:____/____/_____ Address:_____.

City:_____ State:_____ Zip:_____ Phone Number: (___)_____.

E-mail:_____.

Emergency Contact:_____ Phone Number:_____.

How did you hear about our spa? (Please specify)_____.

Assignment of Financial Responsibility

I agree that I am responsible for the charges in full for services rendered. I agree to pay all finance charges, billing charges and all collection fees that may be incurred to collect any balance that may be owed.

Cancellations and Refund Policies

TREATMENTS: All treatments, procedures and/or prepaid packages are non-refundable. Packages are non-transferable and must be used within one year from the date of purchase. Credit from prepaid treatments, procedures, and/or packages may be applied toward other forms of treatment(s) or product(s) only at management's discretion. Credit can be given to and used by purchaser only. **NO REFUNDS - EXCHANGES ONLY.**

PRODUCTS: Many of the products sold in our practice are considered "medical grade" products, and can only be purchased from, or sold by, a licensed professional. We do not accept returns on any product. A spa credit may be issued depending on the circumstance and is at management's discretion. Your signature on this document serves as your acceptance and understanding of our "no return" policy. A copy of this document will be kept in your chart and is available for your review at any time.

CANCELLATIONS: We understand that emergencies do arise; however, we request a 24-hour notice for rescheduling or canceling all appointments. Failure to do so may result in a charge on your account.
"NO SHOWS" WILL BE BILLED FOR THE SCHEDULED TREATMENT.

APPOINTMENTS: To ensure your preferred Doctor or Technician is always available to you, we recommend scheduling your next appointment prior to leaving the Medical Spa. This is particularly important if you are having a series of treatments over a defined period of time. We will always try to schedule you with your requested provider, however, sometimes that provider will not be available and we will place you with our best recommendation.

ARRIVALS: Please arrive on time for your scheduled appointment. This ensures adequate timing for your well-deserved treatment and helps us in not intruding on the following clients' reserved time.

By signing below, I agree to the company's terms and conditions.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

PERSONAL PROFILE & MEDICAL HISTORY (1/2)

Name: _____ Date of Birth: _____

Females: Are you pregnant? ___Yes ___No Are you breastfeeding? ___Yes ___No

Your genetic background affects your skin and its response to many of our procedures. Please specify your ethnic origin:

_____ African American _____ Asian _____Caucasian ____Hispanic
_____ Mediterranean _____ Middle Eastern _____ Native American ____Other_____

Complete the following items of medical history. Please, always inform us of any changes in your medical history and/ or medications.

Please list **all medications** including prescription and over the counter drugs, vitamins, herbs, **blood thinners, aspirin,** and/or supplements.

_____

_____

Allergies to medications?

_____

Please check if any of these conditions apply to you

____ Acne	_____ High Blood Pressure	_____ Precocious Puberty
____ Bleeding Disorders	_____ Hirsutism	_____ Psoriasis
____ Burns/Skin Grafts	_____ Hormone Replacement Rx	_____ Rosacea
____ Claustrophobia	_____ Cold Sores	_____ Implants
____ Seizures	_____ Diabetes	_____ Kaposi's Sarcoma
____ Shingles	_____ Eczema	_____ Keloid Scars
____ Skin Cancer	_____ Endocrine Disorders	_____ Lupus Erythematosus
____ Tattoos	_____ Epidermolysis Bullosa	_____ Thyroid Disease
____ Gold Therapy	_____ Polycystic Ovary Disease	_____ Vitiligo
____ Heart Disease	_____ Port- Wine Stain	_____ Permanent Makeup
____ Herpes	_____ Hepatitis	_____ HIV/ AIDS

Have you suffered from any neurological illness in your past? If yes, please specify:

____ ALS ____ MS ____ Guillain Barre' ____ Myasthenia Gravis

Other:_____

Have you ever had surgery? If yes please specify:

_____

Please describe any other pertinent medical information:

_____

_____

PERSONAL PROFILE & MEDICAL HISTORY (2/2)

If the answer to any of the following questions is yes, please provide details.

1. Have you used Accutane in the last 6 months? Yes No
   a. If yes, how recently? _____
2. Are you currently using glycolic acid or Retin A? Yes No
3. What products are you currently using on your skin? Please describe: _____
_____
4. Do you have any active skin diseases or infections in the area to be treated? Yes No
5. Are you allergic to latex, lidocaine, or any lotions? Yes No
6. Have you had any permanent cosmetic tattooing to the area to be treated? Yes No
7. Do you have any metal or other implants? Where? Yes No
8. Have you had any previous laser or other skin treatments on the area to be treated? Yes No
9. Are there any moles with hair in the area to be treated? Yes No
10. Do you have any history of skin breakouts? Yes No
11. Do you have any scarring as a result from breakouts/acne? Yes No
12. Have you been exposed to the sun within the last four to six weeks? Yes No
    a. If yes, state the approximate date of last exposure _____/____/____
13. Do you use tanning beds. If yes, state the date of last use _____/____/____
14. Do you burn easily in moderate sunlight? Yes No
15. Do you blush easily when nervous? Yes No
16. Do you frequently experience flakiness, tightness or dryness? Yes No
17. Do you use sunscreen on a regular basis? Yes No
18. Have you waxed, used depilatories, bleaches or other chemical processes? Yes No
19. How many glasses of water do you usually drink in a day? _____
20. Do you smoke? Yes No
21. Do you wear contact lenses? Yes No
22. Do you exercise? Yes No
23. Have you had microdermabrasion? Yes No
24. Have you had any chemical peels? Yes No
25. Have you had laser resurfacing? Yes No
26. Do you have wrinkle concerns? Yes No
27. Do you have scarring concerns? Yes No
28. Do you have sun damage concerns? Yes No
29. Do you have pigmentation concerns? Yes No
30. Do you have broken capillary concerns? Yes No

What services are you most interested in? _____

_____

Name of your Primary Care doctor: _____ Phone #: (_____) _____

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

Print Name: _____

Signature: _____ Date: _____
(Parent or Guardian if patient is under 18)

Drops of Beauty Medical Spa Office Policies

At Drops of Beauty Anti-Aging Medical Spa we strive to ensure the highest quality of care and comfort. Our policies have been designed to provide a truly relaxing and tranquil environment. Come join us to *Relax. Restore. Renew.*

Punctuality

Please arrive at least 15 minutes before your scheduled treatment for check-in and any possible clothing changes. If you happen to be late we offer two choices.

- You may shorten your treatment because of time constraints and other clients' schedules.
- You can reschedule your appointment with a $25 cancellation fee to accommodate our professionals.

In case of prepaid vouchers your single treatment will be forfeited. If you would like to reinstate that treatment, a fee equal to the single treatment will apply.

Cancellation Policy

Drops of Beauty Medical Spa understands that you may have to cancel an appointment sometimes. However, we require that a 24-hour notice must be given. Failure to do so will result in a $25.00 charge of your scheduled treatment to your credit card.

Payments

Our available payment options are credit and debit cards (including American Express), cash, Discover and gift certificates.

Gift Certificates

Gift Certificates are available at the reception desk or through the med spa coordinator at the time of your consultation. Gift Certificates are required at the time of service and must be redeemed within one year from the date of purchase.

Tipping and Gratuity

Gratuity is greatly appreciated. Gratuity is not included in your spa treatment certificates, prepaid vouchers or cosmetic procedures. Typical gratuity is 20% of full service price (usually $20 minimum). Gratuity is appreciated for touchups and for complimentary services.

Children and Cell Phone Courtesy

Drops of Beauty Spa is a tranquil environment. To preserve the serenity, please do not bring children to your scheduled appointments and turn off all cell phones. Thank You.

Refunds

No refunds will be given on products, services, and gift certificates. This includes prepaid services including Botox/Dysport and fillers, all retail and all services.

Exchange of Series, Packages and Programs

When purchasing a series of treatments or bundled packages, a discounted rate is given at the time of purchase; payment must be made at the beginning of treatment. The series are non-refundable, and non-transferable. However, should you choose during your series to opt for a different service any remaining balance may be applied to a different treatment. When canceling a series, we deduct full price of used services.

_____

Acknowledgement Signature Date

Arbitration Agreement

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All claims Must be Arbitrated: It is also understood that any dispute that does not related to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a backup for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's prorated share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute the right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to intrude evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgement for future agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should **Initial Here____.** Effective at the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Print Name_____

Office Signature_____ **Date**_____