blue seas medspa

PATIENT INFORMATION

Date_____

Name_____ Date of Birth_____
Home Address_____ City _____
State_____ Zip_____
Cell_____ Email_____

How did you hear about us? _____
Would you like to receive news about our workshops, events, and specials? _____Yes_____No

What are your primary cosmetic/skincare goals/concerns today?

_____

_____

Are you preparing for a special event (wedding, reunion, other)? If so, when?

_____

Skin Care History

Skin Type: This helps us recommend treatments and products that will be safe for you.
Type I - Extremely fair, burns easily, never tans, red and blonde hair, blue eyes
Type II - Fair, burns easily, tans with difficulty, sandy or red hair, green or blue eyes
Type III - Medium, slow to burn, will tan, brown/fair/or sandy hair, green/hazel/or blue eyes
Type IV - Olive, rarely burns, tans easily, brown/dark brown hair, green/hazel/or brown eyes
Type V - Moderate, may never burn, always tans, dark and black hair, brown/dark brown eyes
Type VI – Marked, may never burn, always tans, black hair, dark brown eyes

Products You Currently Use:

Cleanser_____ Eye Cream_____ Exfoliant_____
Moisturizer (day) _____ (night)_____
Retinol/AHA/Glycolic_____ SPF _____
Serum_____ Toner_____ Other_____
Have you ever taken Isotretinoin(Accutane)? _____
Skin Type: Oily Combination Normal Dry Sensitive
How much UV exposure do you get? (sun, tanning beds, driving, etc.) _____
Have you ever had an unexpected reaction to a product or treatment? _____

Besides the purpose of today's visit, please tell us what other interests or areas of concern you have.

Select all that apply:

___Fine Lines/Wrinkles

___Volume Loss

___Dull Skin

___Skin Texture

___Redness

___Acne

___Sun Spots/Dark Spots

___Melasma/ "The Mask of Pregnancy"

___Dark Under Eye Circles

___Unwanted Hair

___Hair Loss

___Inadequate Lashes

___Scarring

___Spider Veins

___Cellulite

___Skin sagging/drooping

___Unwanted Fat (Body and/or Face)

___Body Contouring

___Stress Urinary Incontinence

___Vaginal dryness

___Vaginal Laxity

___Tattoo Modification/Removal

Medical History

Do you smoke?	☐ Yes	☐ No	If yes, how much?_____
Do you drink?	☐ Yes	☐ No	If yes, how much?_____
Do you have allergies?	☐ Yes	☐ No	If yes, to what? _____
Are you pregnant?	☐ Yes	☐ No	
Planning pregnancy?	☐ Yes	☐ No	
Are you nursing?	☐ Yes	☐ No	

Height_____ Weight_____

What medications, vitamins, and/or herbal supplements are you currently using?

_____

_____

Health or Chronic Issues

Select all that apply:

Seizure/Epilepsy	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Stroke or Paralysis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Eczema	☐ Yes	☐ No	Varicose Veins	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No	Blood Clots	☐ Yes	☐ No
Easy Bruising	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Asthma/Emphysema	☐ Yes	☐ No
Herpes	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Autoimmune Disorder	☐ Yes	☐ No
Anxiety/Depression	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No

Notes:

I have read this questionnaire and have disclosed my medical history to the best of my knowledge.

Patient Signature_____ Date_____

Physician Signature _____ Date_____

PERSONAL TREATMENT PLAN

FOR OFFICE USE ONLY

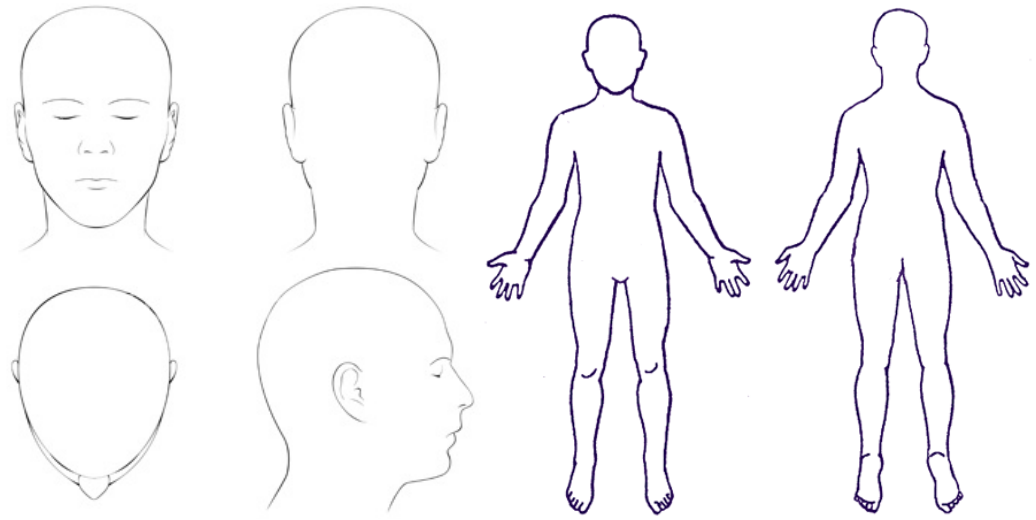
Date _____ Client _____ Provider_____

Goals

Goal #1_____ Target Date_____

Goal #2_____ Target Date_____

Goal #3_____ Target Date_____



Treatment and Budget Plan

Tx#	Mo/Yr	Treatment	Budget Range
1			
2			
3			
4			
5			

Product and Homecare Plan

AM REGIMEN	PM REGIMEN

HIPPA PATIENT CONSENT/ RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthy care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthy care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the Patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices, should it become necessary within the law.
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I am a patient of Blue Seas Med Spa. I hereby acknowledge receipt of Blue Seas Med Spa's Notice of Privacy Practices

Name (please print):_____

Signature: _____

Date: _____

FINANCIAL POLICY

Payment is required for all services at the time they are rendered. Blue Seas Med Spa accepts payment in the form of cash, checks, Visa, Mastercard, Discover and American Express.

We also participate with CareCredit and GreenSky. CareCredit and GreenSky are both financing options designed to help you finance your health, beauty and wellness expenses by providing a way to pay for the treatments and procedures you want — for yourself and your family — right away (subject to credit approval).

If a check is returned to the office due to insufficient funds, the original check amount plus a $25 returned check fee must be received within 30 days from the date the check was returned to avoid further late fees and/or collection action.

Please help us better serve you and our other patients by keeping all scheduled appointments. If you must change an appointment, please do so at least 24 hours prior to your scheduled appointment time.

If there are three no show or late cancelled appointments, the client will be required to pay a $50 booking deposit for all future appointments.

Cosmetic treatments are not covered by insurance

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____