**ADVANCED MEDICAL AESTHETICS** **Client Registration**
**1002 E McDowell Rd, Suite A**
**Phoenix, AZ 85006**

Name: _____ Date: _____

Birthdate: _____ Age: _____ Sex: Male Female Ethnicity: _____ Race: _____

Primary Language: _____

Mailing Address: _____ City, State Zip: _____

E-mail: _____ Would you like to receive emails for specials on products and/or marketing promotions: Yes _____ No _____

Home Phone: _____ Work: _____ Cell: _____ Consent Messages Brief □ Extended □

Marital Status Single Married Other

Emergency Contact: _____ Phone: _____

Referred by: (Circle one)

E-mail Special Social Media Friend/Relative (please provide name) _____

Open House Flyer Website Doctor Office/Other (please provide name) _____

List what areas you are interested in having treated and your expectations after your treatment process:

**Appointment Policy.** As a courtesy, our office will call prior to your appointment to you of your appointment. **We require 24 notices for all cancellation and/or reschedule appointments, failure to do so will result in a $50 charge. Automatic NO SHOW will be charged the same fee of $50.** Our office will make every effort to see patients on time and we expect the same respect from our patients. **Return checks.** A $35 fee for non-sufficient funds will be required from the patient as well as the balance due. No further checks will be accepted. **REFUND POLICY**: All treatment, procedures, services, and product sales are final. Once a procedure has been provided, there are no refunds. Therefore, before a service is performed, please consider all the required protocols and side effects. Cosmetic services are elective and there are no guarantees as to the outcome results or patient satisfaction. We are committed to client satisfaction and are available to answer any questions you may have before your procedure.

**AUTHORIZED TO RELEASE/OBTAIN INFORMATION:** I hereby authorized this physician/clinic to release or obtain any information required in the course of my examination or treatment which could include HIV, Communicable disease, drug abuse information, external drug history. We/or our delegate may contact you by phone at any number you have provided including wireless numbers, by text or email using pre-recorded/artificial voice message and/or automatic dialing and messaging device, as applicable. **AUTHORIZED TO PAY:** I hereby authorized payment directly to the business office of this physician/clinic for the surgical and/or medical benefits, if any, otherwise payable to me for services provided I understand that I am financially responsible for the charges not covered by my insurance.

**Signature:** _____ **Date:** _____

# HIPPA PRIVACY NOTICE

**This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information.**

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

Background: in 1996, congress recognized the need for national patient privacy standards and, as part of the Health Insurance Portability and Accountability Act, abbreviated HIPPA, ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for back accounts, credit cards and even video rentals.

- By law consent is not required to discuss your medical treatment with your other doctors or healthcare providers. This also allows for a prescription to be called into your pharmacy and for scheduling of surgery in a hospital.
- Additionally, none is needed in the course of carrying out healthcare operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or the use of sign in sheets.
- However, this office has always gone one step further in protecting you and does not believe on releasing specific information about you to any business or governmental entity without your written consent.
- Specific authorization is required to disclose protected information in a non-routine circumstance such as to your employer or for use in marketing a product to you.
- Medical information about you may be released for research and public health uses, as long as you are not individually identified.
- You are guaranteed access to review your medical record, and you may amend the record if you believe it to be incomplete or inaccurate.
- You have the right to review when and to whom your information was released.
- You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.
- Portions of this notice may be modified as long as you are notified.
- Should you believe that your privacy rights have been compromised, you may report the violation without penalty to you, to this office, or the Secretary of Health.
- The law requires that you acknowledge receipt of this notice; this has been included on the signature release on your registration form.

I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider's participation in the statewide Health Information Exchange (HIE). Or I previously received this information and decline another copy.

_____ _____

Signature of patient or responsible party Date

# Privacy Release of information

Advanced Medical Care
Josef Khalil MD

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Patient Name: _____

I permit that the following person may be contacted with regards to my health information.

| Name | Relationship to patient | Phone |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

(You must list your spouse and/or children's name separately- if they are not listed, we will not be able to authorize any information regarding your health, appointments and specialist information ect.)

Signature of patient or responsible party Date

Printed name of signed patient or responsible party Date

**MEDICAL HISTORY FORM**

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female _____ Male _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas or condition would you like treated?(please list treatments you are interested in or here for today)

_____

Select ONE description that would best describes what happens to you when you are exposed to strong sun with no sun block:

1. Always burn and never tan _____ 2. Always burn, sometimes tan _____

3. Sometimes burn, always tan _____ 4. Rarely burn, always tan _____

5. I have moderately pigmented skin _____ 6. I have darkly pigmented skin _____

**Please answer all of the following questions YES or NO**

1. Do you have **ANY** current or chronic medical illnesses? Yes ☐ No ☐

   *Disclose any history of Epilepsy, heart urticaria, diabetes, autoimmune disorders-Lupus, or any immunosuppression, blood disorders, cancer, radiation exposure, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.*

   Please List:

   _____

   _____

2. Do you have **ANY** current or chronic skin conditions? Yes □ No □

*Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.*

Please List: _____

3. Are you currently under a doctor's care? Yes□ No □ If so, for what reason?

_____

4. Do you take/use **ANY** medications (prescriptions and non prescription medications), vitamins, herbal or natural supplements, on a regular or daily basis? ( Saint Johns Warts or Fish Oils or blood thinners such as Coumadin) Yes □ No □

Please List:

_____

5. Are there any topical products (both medical and non-medical) that you

use on your skin on a regular or daily basis?

(Retinol or Accutane)

Please List:

_____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? Yes □ No □

7. Do you have **ANY** allergies to medications, foods, latex or other substances? Yes □ No □

Please List: _____

8. (For women) are you or could you be pregnant? Yes □ No□

9. (For women) have you ever been diagnosed with Polycystic Ovarian Disorder? Yes□ No □

( if yes hair removal is hormonal so you may be resistant to treatment, hair will thin noticeably and soften but may not be completely removed)

10. Do you have a history of herpes I or II in the area to be treated? Yes □ No □

11. Do you have a history of keloid scarring or hypertrophic scar formation? Yes□ No □

12. Do you have a history of light induced seizures? Yes □ No □

13. Do you have any open sores or lesions? Yes □ No □

14. Do you have any history of radiation therapy in the area to be treated? Yes □ No □

15. In the last six (6) months, have you used any of the following: Yes □ No □

anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: _____

_____

16. In the last three (3) months, have you used any of the following products:

glycolic acid or other alpha hydroxy or beta hydroxy acid products; exfoliating or resurfacing products or treatments? Yes □ No □

Please List product name and date last used: _____

17. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.? Yes □ No□

If yes, please list locations on or in the body and dates: _____

_____

18. Do you have or have you ever had any Botulinus, such as Botox® or Dysport®? Yes □ No □

If yes, please list locations on or in the body and dates: _____

19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? Yes □ No □

20. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months? Yes □ No □

21. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? Yes □ No □

22. Do you plan on being in the sun for the duration of your treatments? Yes□ No □

Finally, please tell us about your current home skin care regimen:

Cleanser: _____ Toner/Astringent: _____ Exfoliator: _____

Moisturizer: _____ Eye Cream: _____

Print Name: _____ Signature:_____ Date:_____

# ADVANCED MEDICAL AESTHETICS

Refund Policy:
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Printed Name: _____

Signature: _____

Date: _____