Nu-Reflections Medspa, LLC

Client Information *Please fill out ALL fields below

Last: _____ First:_____ Middle_____

Address:_____

City_____ State_____ Zip _____

*Home Phone_____*CellPhone_____

E-mail _____ Age_____ Birth date_____

Sex: ☐Female ☐Male

Client Employer:_____Occupation:_____

Emergency Contact Name: _____

Relationship to Client:_____*CellPhone_____

Nu-Reflections Medspa, LLC has a **24-hour cancellation policy** for all Services, if a cancellation within the 24 hours occurs you will be given a courtesy reminder, If multiple cancellations occur you may be required to pre-pay for future services.

How did you first hear about Nu-Reflections Medspa, LLC?

❑Social Media ❑Internet Search ❑Google ❑Flyer or Paper Ad ❑Facebook/Yelp
Other_____

❑Current client, who can we thank for your referral? _____

Health Information

*Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge. Reason for Visit: _____

Preferred Pharmacy: _____

Height: _____ Weight: _____

Do you have or have you had any of the following: (Circle for each and provide explanation below if Yes)

Aids/HIV ☐
Anxiety Disorder ☐
Arthritis ☐
Asthma ☐
Rheumatoid Arthritis ☐
Bleeding Disorder ☐
Sinus Problems/Infections ☐
Hepatitis/Liver Problems ☐
High Blood Pressure ☐
Cardiac Disease ☐

Chest Pain ☐
Cancer_____
Deep Vein Thrombosis (DVT) ☐
Neck Problems ☐
Infectious Disease ☐
Depression ☐
Diabetes ☐
Epilepsy/Seizures ☐
Eye/Vision Problems ☐
Fibromyalgia ☐

Hay Fever/Allergies ☐
Headaches/Migraines ☐
Hematologic/Blood Disease ☐
High Cholesterol ☐
Kidney/Bladder/Bowel Problems ☐
Pacemaker/defibrillator ☐
Pulmonary Disease ☐
Physical Restrictions ☐
Thyroid Disease ☐
Tuberculosis ☐

Are you **Pregnant** or **Breastfeeding**? Yes ☐ No ☐

List any other serious illnesses and/or accidents, or explanations from list above:_____
_____
_____

List all **MEDICATIONS** you are currently taking or **HAVE TAKEN IN THE LAST MONTH**. Please include the name, dosage, and frequency.

_____
_____

List all **VITAMINS/MINERALS/SUPPLEMENTS** you are currently taking or **HAVE TAKEN IN THE LAST MONTH**. Please include the name, dosage, And frequency._____

_____

List ALL **ALLERGIES**: (Including Latex, antibiotics, topical ointments/creams, or over the counter meds).
_____

*I pledge with my signature the information provided on this document is accurate and complete to the best of my knowledge.
Signature:_____Date:_____

Nu-Reflections MedSpa

Social Health Information

*Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Name: _____DOB:_____

Do you smoke tobacco or use electronic device/vaporized smoking device? **No**☐ **Yes**☐

If yes, specify how much/often? _____

If you have smoked any of the above in the past, when did you quit?_____

Do you use any recreational drugs? (Including marijuana/medical marijuana) **No**☐ **Yes**☐

If yes, specify how much/often?

_____

Have you use any steroids in the last year? **No**☐ **Yes**☐

If yes, specify how much/often?

_____

Do you drink alcohol? **No**☐ **Yes**☐

If yes, specify how much/often?

_____

Do you take aspirin or ibuprofen medications frequently? **No**☐ **Yes**☐

If yes, specify how much/often?

_____

Do you exercise? **No**☐ **Yes**☐

If yes, specify how many times per week?

_____

Do you have problems with scarring? **No**☐ **Yes**☐

If yes, please describe: _____

Do you have any big events/celebrations/family gatherings/pictures scheduled in the next 2 weeks? **No**☐ **Yes**☐

*I pledge with my signature the information provided above is accurate and complete to the best of my knowledge.

Client Signature: _____**Date**: _____

Photography/Video Consent

I, _____, consent to the taking of before/after photos by Nu-Reflections Medspa of my progress in connection with the treatment/procedure(s) intended to be performed. I understand that photographs/video may be taken before, during, and after my treatments/procedure(s) as a routine part of my care. I further understand these photographs/video will be kept strictly confidential.

Client Signature:_____ **Date**: _____

Release of Photography/Video Consent

Additionally, I authorize the use of my photographs/video in the formats listed below. I waive any right to inspect or approve the finished product, (photo/video)for advertising, educational purpose, or other copies that may be used in connection with my options listed below. I understand that I will **NEVER** be identified by name in any use of the images/video, but that in some circumstances the photos/video may portray features which may make my identity recognizable.

(Please initial **Yes** or **No** for each item below)

Yes _____ No _____ – (Fully) On our website, marketing material, articles, or printed published photo galleries for prospective patients to see and understand outcomes from treatments/procedures from Nu-Reflections Med Spa. Additionally, patient/physician education materials to be used during lectures/presentations for research purposes.

Yes _____ No _____ – (Partially) For our in office photo gallery to help the education of future patients to understand and see possible outcomes of treatments/services with Nu-Reflections Medspa LLC. There will not be any rec

*By signing below, I confirm my consent and authorization for the use of my photographic/video content in the way I attended above by Nu-Reflections Medspa LLC .I acknowledge that my consent is voluntary and that I may update this form at any time upon request to a staff member at Nu-Reflections Medspa, LLC .

Cient/Legal Guardian Signature: _____**Date:**_____

Relationship to patient:_____

HIPAA Notice of Privacy Practices for Nu-Reflections Medspa

HIPAA Information and Consent Form The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

I hereby authorize the use and/or disclosure of my individually identifiable health information to Nu-Reflections Medspa for use in the direct treatment of my care. This release encompasses the portion of my medical chart as it pertains to the care provided to me by Nu-Reflections Medspa LLC and any employee of Nu-Reflections Medspa LLC . This release allows portability of my medical chart as it pertains to Nu-Reflections Medspa LLC and the current Nu-Reflections Medspa LLC location as well as future office locations. **Our Obligations:** We are required by law to:

- Maintain the privacy of protected health information;
- Give you notice of our legal duties and privacy practices regarding health information about you;

Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text can be obtained from Nu-Reflections Medspa, LLC.
What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov. We have adopted the following policies: 1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information. 2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative. 3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA. 4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties. 5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor. 6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services. 7. We agree to provide patients with access to their records in accordance with state and federal laws. 8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient. 9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.
Printed Name: _____ Date: _____
Date of Birth:_____

Signature of Client/Legal Guardian: _____

Consent for Contact Regulated by the Telephone Consumer Protection Act (TCPA): You agree, by providing Nu Reflections Medspa, LLC with your landline or cell phone number(s), you give express authorization to be contacted at those numbers, as well as authorize such contact by our agents and assigns in conjunction with your direct care. This express authorization also applies to any landline or cell phone number(s) you may acquire in the future. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable**. Methods of contact may also include leaving voicemails regarding your care.** Providing your phone numbers(s) is not a condition of receiving our services.

By signing here, I _____ acknowledge I have read this disclosure and agree that I may be contacted as described above.

Signature of Client/Legal Guardian: _____ Date:_____

By signing this document I am acknowledging that I have read/discussed the medical history with the above signing client.

Nurse Practitioner signature_____Date:_____

MD Signature_____Date:_____