Medical History Form

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Name _____ Date_____

Address _____ City_____ State_____ Zip code _____

Work Phone _(_____)_____ Home _(_____)_____

Mobile _(____)_____ Email Address _____

Date of Birth _____/_____/_____ Sex ❑M / ❑F

You may contact me at (please check all that apply) ❑ Home ❑Work ❑ Mobile ❑ Email

You may leave a detailed message at (please check all that apply) ❑ Home ❑Work ❑ Mobile ❑ Email

Who should we contact in case of emergency? _____

Relationship _____ Phone Number _(____)_____

If a physician, friend, or another patient of anew medspa.clinic referred you, whom may we thank for the referral? _____

How did you hear about anew medspa.clinic?

___ Brochure ___ Passed by ___ Family/Friend ___ Sign ___ Seminar ___ Internet

___ Yellow Pages Magazine:_____ Radio: _____ Other:_____

What are your concerns? Please check all that apply

- ☐ Sunspots
- ☐ Wrinkles
- ☐ Enlarged blood vessels/Veins
- ☐ Flushing of the skin/rosacea
- ☐ Acne
- ☐ Other (Please specify)_____
- ☐ Large pores
- ☐ Hair removal
- ☐ Cellulite/Fat deposits
- ☐ Hair Restoration

How many years have you noticed this problem?_____

Are your present problems getting more pronounced? ❑ Yes ❑ No

Prior treatment (if any) _____

By what method? _____

List all the products you are currently using on your skin: _____

_____

When was the last time you tanned or had prolonged sun exposure? _____

Do you use chemical sun tanning lotions? ❑ Yes ❑ No

Are you planning a holiday in the sun? ❑ Yes ❑ No

Have you ever had skin resurfacing, rejuvenation or chemical peels? ❑ Yes ❑ No

Have you ever had treatments for pigmented lesions? ❑ Yes ❑ No

Are you **ALLERGIC to ANY** medications, drugs, collagen, or chromium? ❑ Yes ❑ No

If yes, please list: _____

Have you ever had ANY reaction to Novocaine, Xylocaine, Adrenaline, Penicillin, any other Antibiotics, Valium, Codeine, or any other pain medicine or foods? ❑ Yes ❑ No

If yes, please describe: _____

List ALL MEDICATIONS (prescription and over the counter) you take either regularly or occasionally:
this includes: pain medication, blood thinners, and vitamins

_____

_____

MEDICAL HISTORY

Have you ever had: (**please circle all that apply**)

Hepatitis	Heart Disease	Ulcers
Liver or Kidney problems	Irregular Heart Beat	Glaucoma
Diabetes	Rheumatic Fever	Emotional issues
Asthma	Thyroid Disease	Psychiatric issues
High Blood Pressure	Phlebitis	Cold sores

Other medical problems:_____

_____

How many alcoholic beverages do you consume per day? _____

How many packs of cigarettes do you smoke per day? _____

Have you had recent lab tests for HIV or Hepatitis? ❑ Yes ❑ No

Dates and Results: _____

Have you ever had problems healing? ❑ Yes ❑ No

Do you have stretched scars, raised scars, thick scars, or keloids? ❑ Yes ❑ No

Do you need to be on antibiotics PRIOR to surgery or any other time? ❑ Yes ❑ No

Have you ever had excessive bleeding during surgery or any other time? ❑ Yes ❑ No

If you answered YES to any of the above, please specify: _____

_____

Patient Signature _____ Date_____

Parent/Guardian Signature: (under 18) _____ Date: _____

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Skin Typing Matrix

Name: _____ Date: _____

Please answer the following questions by circling the number which best describes you. The accuracy of your answers to these questions is VERY important, as they guide us with your skin treatments today and in the future.

Your clinician will total your score during the consultation.

My ethnic origin is closest to:	Very fair (Celtic and Scandinavian)	___
	Fair-skinned Caucasians with light hair and light eyes	___
	Pale-skinned Caucasians with dark hair and dark eyes	___
	Olive-skinned (Mediterranean, some Asian, some Hispanic)	___
	Dark-skinned (Middle Eastern, Hispanic, Asians, some Africans)	___
	Very dark-skinned (African)	___
My eye Color is:	Light blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light brown	2
	Dark brown	3
	Black	4
The color of my skin that Is not normally exposed to sun is:	Pink to reddish	0
	Very Pale	1
	Pale with a beige tan	2
	Light brown	3
	Medium to dark brown	4
	Dark brown - black	5
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when burn resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is so dark I can't tell	6
When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?	Longer than one month ago	0
	Within the past month	1
	Within the past two weeks	2
	Within the past week	3

Total Score: _____

If your score is:	Your skin type is:
0 – 3	1
4 – 7	2
8 – 11	3
12 – 15	4
16 – 19	5
20 – 24	6

Victoria Hagstrom, M.D.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully.

Introduction

This **Notice of Privacy Practices** describes the types of health related information collected by Victoria Hagstrom M.D. and your rights to review and control the disclosures of that information. "Protected Health Information" or PHI means information that can be used to identify you in your capacity as a patient or applicant for health care treatment, payment or operations. PHI is obtained from your applications for health care coverage, and from surveys, claims for payment, filed by health care providers, referrals made by health care providers, and your medical records. PHI may be obtained over the telephone from you. Other sources or your PHI include group health plan administrators, employers, and your employer's business partners such as third party administrators, consultants and other entities engaged in obtaining health care information.
PHI includes the information about your:

- Health History
- Medical Records
- Name, Address, and Date of Birth
- Marital Status
- Gender and Sexual Orientation
- Social Security Number
- Dependents
- Other Similar Information that Relates to Past, Present, or Future Medical Care

Statement of Policy

Victoria Hagstrom M.D. will not tolerate unlawful disclosure or use of your PHI that is in the possession or under the control of Victoria Hagstrom M.D. Disclosure and use of your PHI is limited to those individuals that have a legitimate business or medical need for that information, as explained below.

You Have Rights

To review your PHI that is in the possession or under the control of Victoria Hagstrom M.D. and to obtain a copy of such information, your request should be in writing. You may be charged a reasonable fee for the copies. To request amendments to your PHI, your request for amendments must be made in writing and include the reason for the amendment. To register a complaint concerning your PHI, your complaint must be in writing. To request an accounting of disclosures of your PHI made by Victoria Hagstrom M.D. your request must be made in writing and may cover disclosures made during a period of up to the previous 6 years. To request a restriction on your PHI that may be disclosed, your request must be in writing. Victoria Hagstrom M.D. is not required to agree to this request. You also have the right to that communication regarding your PHI from Victoria Hagstrom M.D. be made at a certain time or location. This request must be in writing. Victoria Hagstrom M.D. will accommodate all reasonable requests.

Use and Disclosure for Treatment

Your PHI may be disclosed to other health care professionals including doctors, nurses, laboratory technicians, medical aestheticians and other health care personnel involved in your care.

Use and Disclosure for Payment

Your PHI may be disclosed by Victoria Hagstrom M.D. to your health plan for purposes of determining your eligibility for payment and eligibility for plan benefits. Your PHI may be shared with persons involved in utilization review, to assist in subrogation of health care claims, or other adjudication procedures.

Use and Disclosure for Health Care Operations

Your PHI may be disclosed for plan operation purposes including underwriting, premium rating, submitting claims for stop-loss coverage, quality review assessments, audits, business planning, legal services, or administrative services.

Non-Routine Disclosures of Personal Health Information

In situations not covered by your consent, Victoria Hagstrom M.D. will ask for your authorization to use or disclose your PHI. This may be to release your PHI for worker's compensation purposes, automobile insurance claims, and marketing or research purposes. Victoria Hagstrom M.D. will use or disclose PHI only in the circumstance and for the specific purpose contained in your authorization, and will use or disclose only the minimum amount of PHI necessary to perform the non-routine function. Generally, you are the only person who can authorize the use or disclosure of your PHI. In some circumstances, authorization may be obtained from a person representing your interests (such as in the case where you may be too incapacitated to make an informed decision or authorization) or in emergency situations where it would be impractical to obtain authorization. Non-routine disclosures may be made to:

- The health plan sponsor for payment or other claims purposes
- Organ donation and tissue transplant entities, id you are an organ or tissue donor
- The military if you are a member of the armed services
- Worker's compensation carriers
- Public health agencies
- Law enforcement personnel
- Coroners, medical examiners, funeral directors
- Legal representatives in response to a court order
- National security and intelligence agencies
- Correctional institutions

Changes to Privacy Practices

Victoria Hagstrom M.D. may change its Notice of Privacy Practices. In that case, an updated Notice of Privacy Practices will be provided to you.

Patient Signature_____ Date_____

Parent/Guardian Signature (under 18) _____ Date _____

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CLINIC POLICY

It is our pleasure and our passion to serve our patients. Our goal is to provide excellent service and medical care in a customized treatment plan.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

I understand I am financially responsible for the full cost of the treatment series, product, or procedure provided. The quoted fee for service or treatment series supplied at the time of consultation applies only to the agreed upon service or treatment series and expires 30 days from the date of the quote. anew medspa.clinic reserves the right to adjust the fee schedule after the 30 day expiration.

I understand that full payment is expected on or before the date service or procedure is received. Refunds for services performed will not be provided.

I understand that most services are not subject to insurance compensation. If insurance is applicable, Dr. Hagstrom will provide documentation of service to me for submission to my insurance company or cafeteria plan.

I understand that my individual outcome for service or product provided is subject to variable result, and is influenced by genetic factors, sun exposure, smoking and home care regimens. Many services may require a series of treatments to achieve and maintain the desired result. Alternative treatment regimens may be recommended during a course of treatment, based on individual response.

I understand that anew medspa.clinic sells prescription products, therefore is not able to accept returns or exchanges on products.

I understand that in consideration of other patients, anew medspa.clinic requires a 24hr. cancelation notice to any appointments I have scheduled. Failure to do so may result in $50 deposit or pre-payment for future services. anew medspa.clinic also reserves the right to reschedule my appointment should I be later than 15 minutes past my scheduled time.

I understand that my photograph will be obtained before and after treatment is provided, and occasionally during treatment phase as recommended by staff. My photograph will remain in a confidential file for view by medical staff and myself as required to provide adequate treatment recommendations and modification. The photographs may be published in Scientific Journals, promotional materials, and at medical conferences, clearly not revealing my identity.

Prescription Policy: Once anew medspa.clinic and Dr. Hagstrom have been established as your healthcare provider of hair restoration, skin rejuvenation, or body contouring services, relevant prescriptions may be provided (per Dr. Hagstrom's discretion), appropriate to your medical care, for one year from date of last service visit. This will be accomplished through purchase of services or product or by paid office visit. Initial complimentary consultation does not qualify for prescription privileges.

I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAVE HAD THEM ANSWERED TO MY SATISFACTION. CONTINUED CONSENT: BY SIGNING THIS DOCUMENT, I UNDERSTAND AND AGREE TO THE ABOVE POLICY FOR FUTURE SERVICES RENDERED BY ANEW MEDSPA.CLINIC.

Patient Signature:_____ Date: _____

Parent/Guardian Signature: (under 18) _____ Date: _____