RENEW
SKIN SOLUTIONS

Date _____

Name_____DOB_____Age_____

Address_____City_____State_____Zip_____

Best Contact #_____Email_____

Referred By_____

Emergency Contact_____

Employer_____Occupation_____

Business Address_____Business Phone_____

Marital Status_____Primary Care Physician_____

May we leave messages on your answering machine?___Yes___No Send you mail?___Yes __No Email you?___Yes___No

Text you? __Yes__No

Allergies:

Please list any food or drug allergies: _____

_____

Lifestyle Information:

- Do you take daily aspirin?____Yes____No
- Do you smoke?____Yes____No
- Do you wear daily sunscreen___Yes____No
- What SPF on face?_____On body?_____
- Do you use tanning booths?____Yes____No
- Are you pregnant, lactating, or planning to get pregnant?____Yes____No

Skin Care History:

Please indicate by brand name the products that you use for daily skin care and bring them to your appointment:

_____

_____

_____

_____

_____

_____

What would you like to achieve with you treatment or skin care recommendations?

_____

_____

_____

_____

_____

What would you like to discuss with us today?_____

_____

_____

_____

_____

Cosmetic History

___Botox Injections
___Juvederm/Restylane/Collagen injections
___Laser Treatments
___Chemical Peels (date)_____
___TCA or Phenol peel in the last year
___Dermabrasion, Laser resurfacing
___Microdermabrasion
___Waxing/Tweezing/Electrolysis within the last four weeks
___Sun Sensitivity
___Tattoos/Permanent makeup
___Rosacea/Facial redness
___ Acne
___Facial surgery/Face lift (date) _____

Are you presently under the physician's care for any conditions? If so, please describe:

_____

_____

_____

_____

_____

_____

Please list all medications you are currently taking, including any herbal or over the counter medications:

_____

_____

_____

_____

_____

Have you ever had a reaction to any of the following?

___ Cosmetic Medications ___Food
___ Sunscreens ___Fragrance

RENEW
SKIN SOLUTIONS

Medical History

Have you ever had any of the following:

___ Amyotrophic lateral sclerosis
___ Motor Neuropathy
___ Myasthenia Gravis
___ Lambert-Eaton Syndrome
___ Dysphagia
___ Multiple Sclerosis
___ Neuromuscular Disorders
___ Light Sensitive Epilepsy
___ Stroke
___ Seizure
___ Persistent Headache or Dizziness
___ VP Shunt
___ Asthma
___ Breathing Difficulty
___ Emphysema
___ Bronchitis or Hay Fever
___ Heart Disease
___ Chest Pain/Palpitations/Heart Murmur
___ Bleeding Abnormalities
___ Pulmonary Embolism/Blood Clot
___ Leg Ulcer or Phlebitis
___ Blood Thinning Medication
___ Coumadin or anti-clotting medication
___Pacemaker/Implanted Defibrillator
___ Abdominal Pain
___ Constipation
___ Nausea/Vomiting/Diarrhea
___ Jaundice
___ Hepatitis
___ Diabetes
___ Weight Loss or Gain
___ Urinary Problems (Frequency or Pain)
___ Joint Pain
___Broken Bones

___ Swollen Glands
___Abnormal Teeth
___Abnormal Nails
___Fever/Chills
___Polycystic Ovarian Disease (PCOD)
___Cystic Acne
___Scars that turn white or brown
___Lupus or other Auto-immune Deficiency
___ Cochlear Implants
___ Lasik Surgery (date)_____
___Implants (location)_____
___ Reaction
___ Herpes Simplex or Fever Blisters
___Rheumatoid Arthritis "Gold Therapy"
___ HIV
___Cancer (describe)_____
___Hirsutism
___Transplant Anti-rejection Drugs
___Birthmarks
___Treatment with Accutane (date)_____
___Treatment with Tetracycline in last month
___Keloid or Thick Scarring
___Psoriasis or Vitiligo
___Family History of Birthmarks
___Family History of Rashes or Skin Disease
___Family History of Asthma
___Family History of Hay Fever
___ Family History of Cancer
___ Family History of Diabetes
___ Family History of Bleeding Disorders
___Lactose Intolerance
___Blood in Urine or Incontinence
___ Muscle Aches

Explain anything checked above_____

_____

_____

I understand that all procedures and office visits are considered cosmetic regardless of exclusions from my insurance company. I understand and agree to pay in full for all services rendered on the day of these services are performed.

Signature:_____Date: _____

RENEW
SKIN SOLUTIONS

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required or required by law. It also describes your rights to access and control your PHI. "PHI" is information about you, including demographic information, that may identify you, that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses & disclosures of protected health information:**
Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and for treatment purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Payments: Your PHI will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to a medical students that see patients at our office. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign your name and asked to specify your physician. We will also call you by name in the waiting room when your physician is ready to see you. We may also use your PHI as necessary to contact you about your appointments.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Oversight: Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement: Coroners, Funeral Directors and Organ Donation; Research; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures: Under the law, we must make disclosures to you when when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance requirements of section 164.500.

Other permitted and required uses and disclosures will be made ONLY WITH YOUR CONSENT, authorization or opportunity to object, unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

RENEW
SKIN SOLUTIONS

Your Rights: The following is a statement of your rights with respect to your Protected Health Information(PHI)

You have the right to inspect and copy your PHI. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your PHI. This means you can ask us not to use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to any family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and whom you want the restriction to apply.

Your physician is not required to agree to restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request and receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/before April 14, 2003.

We are required by law to maintain the privacy and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at (530) 243-6085

Signature below is acknowledgment that you received this Notice of Privacy Practices.

Print Name_____Signature_____Date_____

RENEW
SKIN SOLUTIONS

24 Hour Cancellation Policy

A 24-hour notice of cancellation or reschedule is required for all office appointments. A missed appointment is a lost opportunity to serve another patient. A $50.00 fee may be charged for each appointment scheduled, but not attended, due to the patient not calling at least 24 hours prior to the scheduled appointment. If a patient arrives ten or more minutes after their appointment start time, the patient may still be seen on a case by case scenario if the schedule permits, however it is not guaranteed.

A credit or debit card is required to be put on file at the time of scheduling all appointments. If a patient is to violate this 24-hour policy, the card on file will automatically be charged the $50 fee.

I acknowledge full financial responsibility for services rendered by Renew Skin Solutions. I understand that I am responsible for rescheduling or canceling appointments at least 24 hours prior to my scheduled appointment time, or I will incur a fee.

Signature: _____ **Date: _____**

Printed Name: _____

1700 Market St. Suite 100, Redding, CA 96001 - PHONE: 530-605-4555 - FAX: 530-241-7786

Patient Name: _____

RENEW
SKIN SOLUTIONS

Skin Typing

Score	Questions	0	1	2	3	4
	What is the color of your eyes?	Light: Blue, Gray or Green	Blue, Gray or Green	Dark: Blue, Gray, Green or Hazel	Dark Brown	Brown Black
	What is your natural hair color? (at age 18)	Light Blonde or Red	Blonde	Chestnut Brown, Dark Blonde	Dark Brown	Black
	What is your skin color on unexposed areas?	Ivory or Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
	Do you have freckles on sun exposed areas?	Many	Several	Few	Rare	None
	What happens when you stay in the sun too long?	Painful Blistering, Peeling	Mild blistering followed by peeling	Burns sometimes with peeling	Rarely Burn	Never Burn
	How tan do you get?	Rarely or not at all	Light color tan	Reasonable medium tan	Tan very easily to a dark tan	Turn deep, dark brown quickly
	If you tried, could you tan?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose your skin to the sun or tanning bed?	More than three months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than two months ago
	How often do you tan the area to be treated?	Never	Hardly ever	Sometimes	Often	Always

Total Score: _____ Score

Skin Type: _____

Score	Type
0-7	I
8-16	II
17-25	III
26-30	IV
>30	V and VI

What is your ethnic background?(circle all that apply)

African American Native American
Latino Mediterranean Asian
Indian Caucasian Italian
Italian Irish/Scottish
European German