Allure Cosmetic Laser Center Client Medical History

Patient Name _____ Date _____

Address _____ City, State, Zip Code _____

Cell Phone _____ Alt. Phone _____ Work Phone _____

Email Address _____ Date of Birth _____

Occupation _____ Employer _____

How were you referred to our office?

American Health & Beauty _____ Spa Finder _____
Brides Magazine_____ Allure Website _____
Internet Search _____

Patient _____ Who? _____

Physician _____ Who? _____

Other _____ _____

I would be interested in more information on the following procedures:

Laser Hair Removal _____ Hormone Balancing _____
Microdermabrasion _____ Body Contouring / Skin Tightening _____
Chemical Peels _____ Smart Lipo / Tickle Lipo _____
Foto-Facials _____ Fractional Laser Resurfacing _____
Injectables & Fillers _____ Laser Skin Resurfacing _____
BLU-U Treatment _____ Spider/Varicose Vein Therapy _____
ST Refirme _____ (Non-Invasive) Fat Reduction Treatments _____

This critical information is used to develop a customized skin treatment for you. Please provide the following information:

HEALTH

Within the last year, have you been under a dermatologist's care? ☐Yes ☐No
Dermatologist's Name: _____

Have you had any of these health problems in the past or present?
☐cancer ☐diabetes ☐epilepsy ☐heart problems ☐hormone imbalance ☐spinal injury ☐hysterectomy ☐thyroid condition ☐varicose veins ☐systemic disease ☐liver ☐kidney ☐asthma ☐lung ☐constipation ☐hypertension ☐blood pressure ☐thromboses ☐HIV positive ☐hepatitis
If yes, please explain: _____

Do you follow a strict diet? ☐Yes ☐No

Do you take any vitamins, prescribed drugs, blood thinners, diet pills, minerals, over the counter meds and or supplements? ☐Yes ☐No
If yes, please list: _____
Do they make you photosensitive? ☐Yes ☐No

Do you use any acne medications or antibiotics (oral or topical)? ☐Yes ☐No
For example: Renova, Accutane, Zovirax. Please list: _____

Are you allergic to any cosmetic ingredients/medications? Please list **ALL** medicines or cosmetic ingredients that you are allergic to or had reactions of any kind: _____

Have you ever had a reaction to any of the following? ☐cosmetics ☐medicine ☐iodine ☐pollen ☐hydroxy acids ☐animals ☐fragrance ☐sunscreens ☐salicylic acids ☐seafood/food ☐other: _____

_____

How much water do you drink daily? _____

How many alcoholic beverages do you consume weekly? _____

Do you smoke? ☐Yes ☐No

Do you exercise regularly? ☐Yes ☐No

Do you have regular sleep patterns? ☐Yes ☐No

Do you wear contact lenses? ☐Yes ☐No

Do you have metal implants or a pacemaker? ☐Yes ☐No

Have you had or planning to have any surgery? ☐Yes ☐No
If yes, please specify: _____

Do you burn easily in moderate sunlight? ☐Yes ☐No

Do you blush easily when nervous? ☐Yes ☐No

Do you have a tendency for redness? ☐Yes ☐No

Do you suffer from sinus problems? ☐Yes ☐No

Do you sweat easily? ☐Yes ☐No

Do you drink caffeinated beverages (coffee, tea, soft drinks)? ☐Yes ☐No
How many daily? (combined) _____

Do you ever experience a burning, itching sensation on your skin? ☐Yes ☐No
Where? _____

How is your pain tolerance? ☐Low ☐Medium ☐High

What type of massage pressure do you prefer? ☐Soft ☐Medium ☐Firm

FEMALES

Are you taking oral contraceptives? ☐Yes ☐No

Have you changed brands of contraceptives within 6 months? ☐Yes ☐No

Are you pregnant / lactating or trying to become pregnant? ☐Yes ☐No

Is your menstrual cycle regular? ☐Yes ☐No

Do you have unwanted hair on your face or breasts? (hormones) ☐Yes ☐No

MALES

What is your current shaving system? ☐electric ☐wet shave ☐dry shave

Do you experience ingrowns or irritation from shaving? ☐Yes ☐No

SKIN

What conditions/problem areas would you like improved? ☐sun damage/age spots ☐excessive oiliness ☐acne/pimples ☐freckles ☐clogged pores ☐upper lip lines ☐wrinkles/frown lines ☐dry patches ☐scarring ☐facial hair/ingrowns ☐broken capillaries ☐brown spots/uneven tone ☐blackheads/whiteheads ☐hard bumps under skin/milia ☐warts ☐rosacea ☐other: _____

Do you experience any of the following? ☐psoriasis ☐dermatitis ☐fever blisters/cold sores ☐rosacea ☐eczema ☐moles ☐warts ☐dehydration ☐dry scalp ☐cellulite ☐flakiness of skin ☐tightness ☐keloids

Any facial scarring? ☐Yes ☐No
Location: _____ How old is scar? _____

With what temperature of water do you cleanse? ☐cold ☐warm ☐hot

Have you seen any skin changes lately? ☐Yes ☐No
Please explain: _____

Do you sunbathe or use tanning beds? ☐Yes ☐No

Do you ever experience an oily shine during the day on your face? ☐Yes ☐No ☐Occasionally

Do you ever experience skin breakouts? ☐Yes ☐No ☐Occasionally

Is your T-zone oily during the day? ☐Yes ☐No ☐Occasionally

Do you experience skin rashes? ☐Yes ☐No

Which form of hair removal do you use? ☐laser ☐depilatories ☐tweezing ☐electrolysis ☐waxing

Have you ever had chemical peels, laser, microdermabrasion or any resurfacing treatments? ☐Yes ☐No
How long ago? _____

Are you currently using any products that contain the following? ☐glycolic acid ☐lactic acid ☐salicylic acid ☐exfoliating scrubs ☐hydroxy acid ☐retinol ☐hydroquinone ☐other: _____

SKIN TYPE WORKSHEET

Patient Name: _____ **Date:** _____

Score		0	1	2	3	4
	What is the color of you eyes?	Light Blue, Light Gray, or Light Green	Blue, Grey, or Green	Dark Blue, Dark Grey, Dark Green, Light Brown	Dark Brown	Brown-Black,
	What is the natural color of your hair?	Sandy Red	Blond	Chestnut, Dark Blond	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Reddish, Very Pale	Pale with a beige tint	Light Brown	Dark Brown	Black
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful, Severe Burns, Blistering, Peeling	Burns, followed by peeling	Rarely burns	No burns, just darker skin tone.	Never had burns, very little reaction at all to sun exposure
	To what degree do you tan?	Hardly or not at all	Light tan color	Reasonably tan	Tan very easily	Turn dark quickly
	Do you tan several hours after sun exposure?	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 yourself to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total Score:

Skin Type:

Score:	Fitzpatrick Skin Type
I	0-7
II	8-16
III	17-25
IV	25-30
V-VI	Over 30

SOME DRUGS THAT CAUSE PHOTOSENSITIVITY

ANTICANCER DRUGS

Dacarbazine
Fluorouracil
Flutamide
Methotrexate
Vinblastine

ANTIHISTAMINES

Cyproheptadine
Diphenhydramine

ANTIMICROBIALS

Ciprafloxacin
Clofazimine
Dapsone
Demeclocycline
Doxycycline
Enoxacine
Flucytosine
Griseafulvin
Lomefloxacin
Minocycline
Nalidixic Acid
Narfloxacin
Oflaxacin
Oxytetracycline
Pyrazinamide
Sulfonaides
Tetracycline

St. John's Wort

ANTIDEPRESSANTS

Amitriptyline
Amoxapine
Clomipramine
Desipramine
Doxepin
Imipramine
Maprotiline
Nortriptyline
Phenelzine
Protriptyline
Trazodone
Trimipramine

ANTIPSYCHOTICS

Chlorpromazine
Fluphenazine
Haloperidol
Perphenazine
Prochlorperazine
Thioridazine
Thiothixane
Trifluoperazine
Thioflupromazine

ANTIHYPERTENSIVES

Catopril
Diltiazem
Methyldopa
Minoxidil
Nifedipine

ANTIPARASITIC

Chloroquine
Quinine
Thiabendazole

DIURETICS

Acetazolaminde
Amiloride
Bendroflumethiazide
Chlorothiazide
Furosemide
Hydrochlorothiazide
Hydroflumethiazide
Methclothiazide

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CANCELLATION POLICY

PLEASE CALL AT LEAST **24 HOURS** IN ADVANCE
IF YOU NEED TO CANCEL OR RESCHEDULE AN APPOINTMENT.

If you have not arrived to your scheduled appointment 15 minutes after your scheduled appointment time, it will be considered late. We do ask that you do inform the office that you will be running late. With consideration of the Doctor's schedule and depending on the type of appointment that you are scheduled for, we may or may not have to reschedule the appointment for another day. If you are not able to make the appointment at all or need to reschedule your appointment, please call the office 24 hours prior to your appointment or a **$50** cancellation fee will be added to your account.

_____ _____
Please Print Patient's Name Date

_____
Signature of Patient or Legal Guardian

REFUND POLICY

It is our office policy that **NO REFUNDS** will be given at all. Any requests for spa credit must be scheduled for a consultation with the Aesthetician that the treatment was done with or Dr. Leo Capobianco before any credit is given. Deposits or payments made for Tickle Lipo, Smart Lipo, Vein Treatments and ALL our package deals are **NON-REFUNDABLE.**

THANK YOU!

_____ _____
Please Print Patient's Name Date

_____
Signature of Patient or Legal Guardian

Allure Cosmetic Laser Center
Dr Leo J. Capobianco, DO, FAAEM

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.
Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing and/or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use and disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use and disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization. This does include photos taken for before and after pictures for the office.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in the format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make a request in writing) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information (Your request must be in writing and it must explain why the information should be amended). We may deny your request under circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations. You may complain to use using the contact information listed at the end of this Notice. You may also submit written complaint to the U.S Department of Health and Human Services. We will provide you will the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services upon request. We Support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Allure Cosmetic Laser Center
Dr Leo J. Capobianco, DO, FAAEM

ACKNOWLEDGEMENT OF PRIVACY PRACTICES NOTICE

I hereby acknowledge that I have received a copy of this office's Privacy Practices Notice.

_____ _____
Please Print Patient's Name Date

_____
Signature of Patient or Legal Guardian

On this date, I was offered, but I declined a copy of this office's Privacy Practices Notice. I am aware that the Privacy Practices Notice can be found at the Front Desk for my review and I may request a copy at a future date.

_____ _____
Please Print Patient's Name Date

_____
Signature of Patient or Legal Guardian

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A BRIEF LOOK AT ARBITRATION

Introduction
Arbitration is an alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association, and noted to be favored method of resolving disputes by the United States Supreme Court.
If you are unfamiliar with arbitration in general the information included here provides some of the basic principles of arbitration.

What is Arbitration?
Arbitration is an alternative way of resolving disputes. Instead of taking your disagreement through the long and expensive process of court litigation, you and the doctor agree in advance to submit any disputes to an arbitrator for his or her determination. The arbitrator is selected from among the numerous retired judges who are available and qualified to serve on these matters, and is mutually agreed upon by both you and the doctor. After a hearing, which is usually less formal than a court proceeding, the arbitrator makes the decision ("award"). Although the procedures are different, generally the same laws and same measure of damages, which apply in court proceedings, also apply in arbitration.

Does Arbitration prevent you from making a claim?
No. By selection, arbitration as the means to resolve a disagreement, all you are essentially doing is moving the claim to a different forum (example: from a jury to an arbitrator) to hear and ultimately decide your claim.

Does it provide you from obtaining a financial award?
No. Arbitration does not restrict you from obtaining a financial award in any matter. If the arbitrator accepts and agrees with your claim he or she will determine a damage award.
The United States Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditions and economical alternative to the court system.

May an attorney of my choice represent me?
Yes. An attorney of his or her choice, at the his or her own represent any party to arbitration. The arbitrator will hear the facts and decide the matter whether or not lawyers represent the parties.

Who is bound by the agreement?
If you choose to sign the arbitration agreement, you will be agreeing to bond yourself and anyone who could bring suit in connection with treatment or services provided to you by the Doctor. If you sign on behalf of a family member or some other person for whom you have responsibility, you will bind that person as well as anyone who could sue in connection with the treatment or services provided to that person by the Doctor. Likewise, the Doctor or anyone suing on behalf of the Doctor is also bound.

What does arbitration cost?
In general, arbitration is less expensive than court actions. The parties ordinarily share the arbitrator's fees equally. The amount of those fees will depend on upon the complexity and length of the case.

If either party does not like the arbitration result, could there still be a jury trial in court?
Generally, the answer is "no". The whole purpose of arbitration is to avoid the expense, delay and inconvenience of going to court. Arbitration awards may be reviewed, and potentially reversed ("vacated") by a court in limited circumstances.

A Message to Our Patients About Arbitration.
The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the courts.

By signing this agreement you are changing the place where your claim will be represented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal cost for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.
Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with the communication therefore, if you have any questions about your case, please as any of the staff members at front desk.

Allure Cosmetic Laser Center
Dr Leo J. Capobianco, DO, FAAEM

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1- Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, or negligence of any kind that is as to whether any medical services rendered under the contract were unnecessary or unauthorized or were improperly negligently or incompetently rendered, will be determined by submission to arbitration as provided by Nevada law and not by a lawsuit or resort to court process Nevada law provides for judicial review of arbitration proceedings. Both parties i this contract, by entering into it. are giving up their constitutional right to have any such dispute in a court of law before a jury, instead are accepting the use of binding arbitration.

Article 2- All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term, "patient" herein shall mean both the mother and the mother's expected child or children.
Filing by physician of any action in court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3- Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. Mail, postage prepaid, to all parties, describing the claim against the Physician, amount of damages sought, and the names, addresses and telephone numbers of the patient (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statues (NRS 380206-382.48, 41A.035, .045, .097, .100, .120 and damages upon written request to the arbitrator. The patients shall bear their own costs, fees and expenses, along with a pro-rate share of the neutral arbitrator's fees and expenses.

Article 4- Severability Provisions: In the event of any provision(s)of this agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the agreement enforces in accordance with Nevada and Federal Law.

Article 5- Condition of Treatment: I understand that signing this arbitration agreement is not a condition of my receiving medical treatment.

NOTICE: IF YOU CHOOSE TO SIGN THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE WITH MEDICAL MALPRACTICE DECIDED BY A NEUTRAL ARBITRATION. AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE

_____ **INITIAL** HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUMENT TITLED, "A BRIEF LOOK AT ARBITRATION" FOR THE PATIENT.

Allure Cosmetic Laser Center

By:_____ _____
Medical Group Date

By:_____ _____
Patient or Legal Guardian Date

By:_____ _____
Translator (if applicable) Date

By:_____ _____
Physician Date

A signed copy of this document is to be given to patient (if wanted) and original copy is to be filed in Patient's Chart.