



Patient Information

In order to provide you with the most appropriate treatments, we ask that you complete the following questionnaire. All information is strictly confidential.

Please Print: Today's Date: ____/____/____

First Name: _____ MI: _____ Last Name: _____

Birth Date: ____/____/____ Occupation: _____ Present Weight: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone #: (____) _____ - _____ Home Phone #: (____) _____ - _____

Email Address: _____ Work Phone#: (____) _____ - _____

Marital Status: (Please Circle) Married Single Divorced Widowed

Spouse/Significant Other's Name: _____ Phone #: (____) _____ - _____

Emergency Contact Name: _____ Phone #: (____) _____ - _____

How did you hear about us? _____

Referring Friends Name: _____

I am here for: (Please check all that apply)

<input type="checkbox"/> Anti-Aging	<input type="checkbox"/> Hair Removal	<input type="checkbox"/> Laser Treatments
<input type="checkbox"/> Botox/Fillers	<input type="checkbox"/> Hormone Replacement	<input type="checkbox"/> Skin Care
<input type="checkbox"/> Consultation	<input type="checkbox"/> Injections	<input type="checkbox"/> Weight Loss



General Health Information

Please mark each health issue that applies to YOU:

X Condition/Age of diagnosis	X Condition/Age of Diagnosis	X Condition/Age of Diagnosis
<input type="checkbox"/> Asthma/Lung Disease	<input type="checkbox"/> Frequent Cold Sores	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Auto Immune Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pulmonary Embolus
<input type="checkbox"/> Blood Clotting Abnormalities	<input type="checkbox"/> Headaches/Migraine	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Heart Issues	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Cancer (type)	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Confusion/Depression	<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> Skin Disease/Lesions
<input type="checkbox"/> Connective Tissue Disorder	<input type="checkbox"/> Herpes	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Convulsions	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> TMJ
<input type="checkbox"/> Defibrillators	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Varicosities/Phlebitis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hormone Imbalance	<input type="checkbox"/> Other
<input type="checkbox"/> Digestive Disturbances	<input type="checkbox"/> Keloid Scarring	<input type="checkbox"/> Other
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Other
<input type="checkbox"/> Emotional/Psychiatric	<input type="checkbox"/> Loss of Sleep	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lupus	
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Mitral Valve Prolapse	

1. Are you currently under the care of a physician/Dermatologist? Yes No
 If so for what condition? _____
2. Do you have a history of erythema abigne? Yes No
 (A persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation)
3. Do you have any metal or artificial joints? Yes No
 If so please explain: _____
4. Have you ever been diagnosed with any type of cancer? Yes No
 If so, when _____ What type of cancer? _____
5. Do you use tobacco? Yes No
 If yes, how long? _____ How much per day? _____
6. Do you drink alcoholic beverages? Yes No
 If yes, how often? _____



Do you smoke marijuana or use other recreational drugs? Yes No

Please list all medications that you are currently taking. Please include any Hormone Replacement Therapies, herbal or over the counter supplements and any topical medications (i.e. Tretinoin, Retin-A, AndroGel, hormonal patches or creams). _____

When was the last time you used it? _____

Please list any surgeries or hospitalizations: _____

Other medical history for yourself or family: _____

Please list any medications that you are allergic to and the type of reaction. _____

Have you ever had an allergic reaction to the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insect Bites/Stings | <input type="checkbox"/> Nuts |
| <input type="checkbox"/> Benzoyl Peroxide | <input type="checkbox"/> Latex | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Garlic | <input type="checkbox"/> Lavender | <input type="checkbox"/> Pumpkin |
| <input type="checkbox"/> Hydro-Cortisone | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Salicylic Acid/ (Aspirin) |

Patient's Name (Print): _____

Patient's Signature: _____ Date: ____/____/____

Practitioners Signature: _____ Date: ____/____/____



Photo Consent

This consent form authorizes Back To 30™ to use any photographs taken for marketing, medical education, teaching or research. Under no such circumstances will any publications or material bear your name or identifying information. Your refusal to consent to the use of these photographs for marketing, medical education, teaching or research will in no way influence your treatment.

I _____, understand the photographs taken of me shall be used for medical records and if in the judgment of the medial health care professional, marketing, medical research, education or science. Any photography and/or information relating to my case may be published and republished, either separately or in conjunction with each other, in professional journals or Back to 30 website, in all marketing, and for medical education, knowledge or research.

I waive the rights that I may have to any claims for payment of royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless the clinic, staff and consultants from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the following limitation: Under no circumstances will any such publication, film photograph, video tape or material exhibited contain my name or other personal protected information unless voluntarily disclosed by me.

Patient Name (Print): _____

Patient Signature: _____ Date: ____/____/____

Professional Signature: _____ Date: ____/____/____

OR

Please sign one area only (upper or lower)

I _____, only consent for my pictures to be used for medical purposes. They are only for my file and to be kept only to review and monitor my progress.

Patient Name (Print): _____

Patient Signature: _____ Date: ____/____/____

Professional Signature: _____ Date: ____/____/____



Consent for Use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- ❖ We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- ❖ We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- ❖ We may need to use your health information within our practice for quality control or other operation purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy as escribed in that notice. If we make a change to our privacy practices, we will notify you I writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure or your health information; please let us know in writing. We are not required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice (if desired?)

Patient Name (Print): _____

Patient Signature: _____ **Date:** ____/____/____

Representative Signature: _____ **Date:** ____/____/____



Payment Policy:

Full payment is expected at time of all procedures. Special circumstances will be considered and a customized schedule may be arranged. Back To 30™ Management accepts cash, check, and all credit and debit cards. Appointments scheduled in advance may require full payment or a deposit to insure the time allotment for the procedure. _____ (Initial)

Refund Policy:

Back To 30™ Management **DOES NOT** offer refunds on any services or products. _____ (Initial)

Cosmetic Fee Waiver:

I understand that the procedures I have requested to be performed by Back To 30™ Management are elective/cosmetic in nature and **WILL NOT** be submitted to my health care provider or insurance company. I understand that I am fully responsible for payment to Back To 30™ Management, and not my health care provider or insurance company. _____ (Initial)

Back to 30 Cancellation/No Show Policy:

We here at Back to 30 want to thank you for choosing us!

With a package purchase or service down payment today we'd like to inform you of our Cancellation/No Show policy for treatment.

All services that are Cancelled/Rescheduled within 48 hours of scheduled treatment will be subject to a \$50 courtesy charge. The same policy applies for appointments that are unattended. This policy enables us to create an efficient and accessible schedule that gets each client to their treatment desires as soon as possible. In the case of a down payment, \$50 will be deducted from the down payment made before service. In the case of a package purchased, \$50 will be required before the next treatment will be rendered.

We appreciate your understanding and courtesy when scheduling appointments with Back to 30, and we look forward to providing you the best service in the industry.

Client Signature _____ Date ____/____/____

B230 Witness Signature _____