Patient Intake & History

VIDA Skin Beauty Center

Patient Name:_____ Date:_____

Street Address: _____

City:_____ State:_____ Zip Code:_____ Date of Birth:_____

Home #:_____ Work#_____ Cell#_____

Occupation:_____ Other:_____

Email:_____Sex_____ Age_____

Emergency Contact Name: _____ Other:_____

How did you hear about us: ☐ TV ☐ Google ☐ Facebook ☐ Instagram ☐ Yelp ☐ RealSelf

☐ Patient Name:_____ ☐ Other:_____

Skin History

Lines/Wrinkles	☐ Yes	☐ No	Redness/Rosacea	☐ Yes	☐ No
Skin Laxity	☐ Yes	☐ No	Veins	☐ Yes	☐ No
Skin Texture/Scarring	☐ Yes	☐ No	Acne	☐ Yes	☐ No
Brown Spots/Hyperpigmentation	☐ Yes	☐ No	Dermatitis	☐ Yes	☐ No
Skin Growths	☐ Yes	☐ No	Other:_____	☐ Yes	☐ No

Cosmetic Procedure History

Neurtotoxis: Botox/Dysport	☐ Yes	☐ No	Laser Hair Removal	☐ Yes	☐ No
Dermal HA Fillers: e.g Juvederm	☐ Yes	☐ No	PhotoFacial/IPL	☐ Yes	☐ No
Fillers: Sculptra, Artefill, Collagen	☐ Yes	☐ No	Laser Vein	☐ Yes	☐ No
Laser Skin Resurfacing	☐ Yes	☐ No	Cellulite/Fat Loss	☐ Yes	☐ No
Laser Skin Tightening	☐ Yes	☐ No	Peels/Microderms/Facials	☐ Yes	☐ No

Cosmetic Surgery _____ Year_____

_____ Year _____

_____ Year_____

1) Adverse reactions to any of the above? ☐ Yes ☐ No _____

2) Were you pleased with results? ☐ Yes ☐ No _____

Patient Intake & History

VIDA Skin Beauty Center

Patient Name:_____ Date:_____

ALLERGIES

- ☐ Penicillin, Sulfa, _____
- ☐ Morphine, Codeine, hydrocodone
- ☐ Novocain, Lidocaine, anesthetics
- ☐ Tetanus toxoid or serums
- ☐ Adhesive tape
- ☐ Iodine, Betadine, Chlorhexidine
- ☐ Latex rubber
- ☐ Other Allergies:_____

MEDICATIONS (In last 6 months)

- ☐ Nicotine, nicotine patch, smoking
- ☐ Cortisone, prednisone or ACTH
- ☐ Diuretics or water pills
- ☐ Blood pressure medication
- ☐ Steroids/body building drugs
- ☐ Seizure medication
- ☐ Insulin/diabetes medication
- ☐ Headache/migraine medications
- ☐ Asthma medication
- ☐ Heart medication
- ☐ Anticoagulants or blood thinners
- ☐ Pain pills
- ☐ Appetite suppressants or diet pills
- ☐ "Fen-Phen," Redux, Pondimin, phentermine or fenfluramine
- ☐ Sedatives, tranquilizers or sleeping pills
- ☐ Antidepressants, antipsychotics
- ☐ Recreational or illegal drugs
- ☐ Homeopathic/ Herbal medicines
- ☐ Aspirin, Motrin, Advil, Aleve,
- ☐ Anti-inflammatories
- ☐ Vitamin E (excluding E in multivitamin)

PAST MEDICAL HISTORY (PMHx)

- ☐ Anaphylaxis or severe allergy attack
- ☐ Asthma, emphysema or chest disease
- ☐ Pneumonia, chronic cough, COPD
- ☐ Pulmonary embolus
- ☐ Shortness of breath, dizziness or fainting
- ☐ Ankle swelling
- ☐ High blood pressure
- ☐ Heart attack, chest pain, palpitations or irregular heartbeats
- ☐ Rheumatic fever or congenital heart disease
- ☐ Chest pain or angina
- ☐ Angioedema, persistent or unusual swelling
- ☐ Pacemaker
- ☐ Artificial heart valve, mitral valve prolapse
- ☐ Phlebitis, blood clots or varicose veins
- ☐ Blood transfusion
- ☐ HIV or AIDS
- ☐ Anemia or blood disorder
- ☐ Frequent nosebleeds or heavy menstrual periods
- ☐ Easy bruising
- ☐ Abnormal bleeding or clotting
- ☐ Poor circulation, leg ulcers
- ☐ Splenectomy (removal of spleen)
- ☐ Hepatitis, jaundice, cirrhosis or liver disease
- ☐ Bodyache, painful swollen glands, skin blisters
- ☐ Lupus, arthritis or autoimmune disease
- ☐ Chronic fatigue syndrome
- ☐ Artificial joint replacement
- ☐ Diabetes
- ☐ Thyroid problem or Graves' disease
- ☐ Kidney failure, kidney or prostate problems
- ☐ Adverse reaction to surgery
- ☐ ☐ Eye surgery (including Lasik)

PMHx, CONTINUED

- ☐ Alcohol abuse or alcoholism
- ☐ Drug abuse or addiction
- ☐ sychological or emotional problems
- ☐ Depression
- ☐ Personality disorder
- ☐ Bipolar or manic depressive illness
- ☐ Schizophrenia
- ☐ Is there someone close to you, or are there members of your family who strongly object to your having plastic surgery?
- ☐ Is there someone close to you, or are there members of your family who strongly object to your having Cosmetic precedures?
- ☐ Migraines, headaches
- ☐ Bell's palsy or neurological problems
- ☐ Seizures
- ☐ Strokes
- ☐ Glaucoma or cataracts

_____

_____

_____

_____

_____

_____

_____

List any chronic Illnesses: _____

Current Medications & Herbal Supplement: _____

_____

_____

_____

_____

_____

Current Topical Creams/Ointments/Solutions:_____

Anticoagulants or antiplatelet drugs ☐ Yes ☐ No

Immunosuppressant ☐ Yes ☐ No

Accutane within the last 12 months ☐ Yes ☐ No

Anti-Inflammatories/NSAIDS ☐ Yes ☐ No

Ethnicity/Ethnic Background: _____(Important for Laser Treatments)

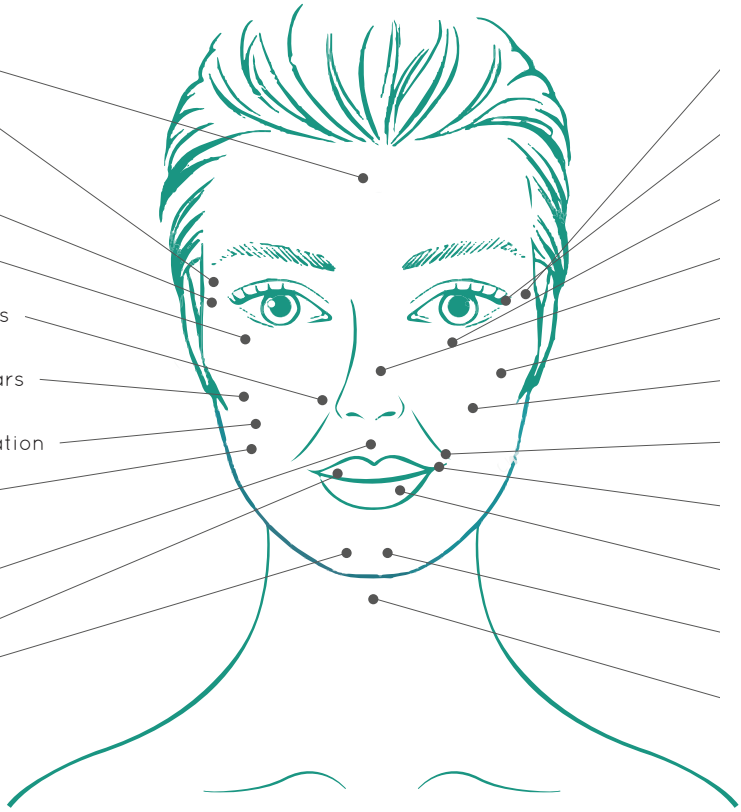
Smoking History ☐ Never Smoked ☐ Ex-Smoker ☐ Light Smoker ☐ Heavy Smoker #Years _____

Sunscreen ☐ Always use ☐ Occasionally Use ☐ Rarely in Sun ☐ Daily in Sun

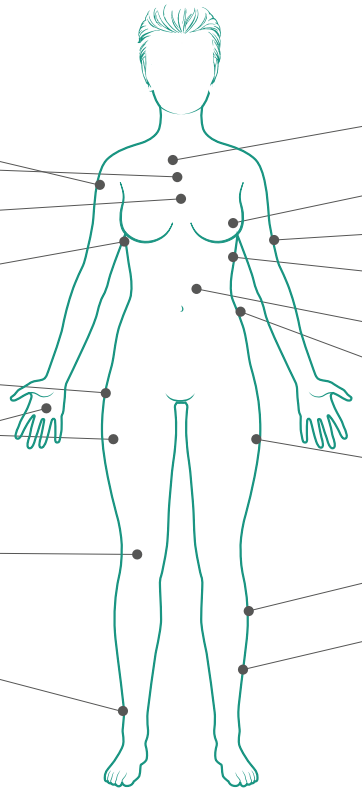
435 Arden Ave., Suite 330, Glendale, CA 91203 Tel 747-257-0777 Fax 877-548-0506

Patient Name: _____ Date: _____

Please mark those areas of the face that bother or trouble you. In the boxes provided please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome). Feel free to draw on the chart to identify any other facial concerns.



- ☐ Forehead Lines
- ☐ Blue Temple Veins
- ☐ Crow's Feet
- ☐ Enlarged Pores
- ☐ Broken Blood Vessels
- ☐ Acne or General Scars
- ☐ Freckles & Pigmentation
- ☐ Melasma
- ☐ Vertical Lip Lines
- ☐ Gummy Smile
- ☐ Acne
- ☐ Temple Hollows
- ☐ Thin & Short Eye Lashes
- ☐ Under Eye Circles
- ☐ Nasal Hump
- ☐ Volume Loss
- ☐ Rosacea or Redness
- ☐ Nasolabial Folds / Smile Lines
- ☐ Marionette Lines
- ☐ Thin Lips / Lip Definition / Lip Fullness
- ☐ Weak Chin
- ☐ Double Chin /Turkey Neck



- ☐ Flabby Arms
- ☐ Brown/Sun Spots
- ☐ Chest Veins
- ☐ Excessive Sweating
- ☐ Cellulite
- ☐ Saddlebags
- ☐ Aging Hands
- ☐ Sagging Knees
- ☐ Tattoo Removal
- ☐ Chest Wrinkles
- ☐ Sagging Breasts
- ☐ Excessive Hair
- ☐ Bra Fat
- ☐ Loose Skin
- ☐ Love Handles
- ☐ Stretch Marks
- ☐ Bulging Veins
- ☐ Leg Veins

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Patient Information

Please check all of procedures that interest you.

- ☐ Photofacials (IPL)
- ☐ Age spots/ Freckles removal (IPL)
- ☐ Sun Damage Repair
- ☐ Erectile Dysfunction - Shockwave TRT
- ☐ Erectile Dysfunction - PRF shot
- ☐ Intimay Repair - Shockwaves TRT
- ☐ Intimacy Repair - PRF shot
- ☐ Hair Removal (IPL)
- ☐ Skin tightening RF - Face & Neck
- ☐ Slimming & Contouring RF - body
- ☐ Cellulite Destruction -Cavitation US
- ☐ Cellulite Destruction - Vacuum Rolling
- ☐ Cellulite Destruction -Mesotherapy
- ☐ Intensive Weight Loss Program
- ☐ Fat Burner Vitamins injections
- ☐ Sexual Rejuvenation
- ☐ PRP/PRF Mirconeedling
- ☐ PRP/ PRF hair grownt
- ☐ PRF Stretch marks
- ☐ PRF Scar Removal
- ☐ PRF Facial Injections
- ☐ PRP Skin Stamping
- ☐ Acne - Microneedling
- ☐ Acne -Light therapy
- ☐ Skin Peels
- ☐ Skin Care products
- ☐ Spidar Veing Removal -Sclerotherapy
- ☐ Spider Veins Removal -(IPL)
- ☐ Hair Growth - Light therapy (PDT)
- ☐ Hair Growht Bioting injections
- ☐ Exosomes Microneedling
- ☐ PDO threads (simple) - wrinkle reduction
- ☐ PDO threads (barbed) - skin Lift
- ☐ Botox - wrinkle reduction
- ☐ Filler (injectables)
- ☐ Angiaging - Saliva Hormone Test
- ☐ Antiaging -blood Micronutrient test
- ☐ Lymphatic Detox (Air / vacuum)
- ☐ Chronic Pain (shockwaves Therapy)

SKIN TYPE	COLOR	REACTION TO UVA	REACTION TO SUN
☐ **Type I**	Caucasian – blond or red hair, freckles, fair skin, blue eyes	Very Sensitive	Always burns easily, never tans, fair skin tone
☐ **Type II**	Caucasian - blond or red hair, freckles, fair skin, blue or green eyes	Very Sensitive	Usually burns easily, tans with difficulty, fair skin tone
☐ **Type III**	Darker Caucasian, light Asian	Sensitive	tans gradually, fair to medium skin tone
☐ **Type IV**	Mediterranean, Asian, Hispanic	Moderately Sensitive	Rarely burns, always tans well, medium skin tone
☐ **Type V**	Middle Eastern, Latin, light-skinned Black, Indian	Minimally Sensitive	Very rarely burns, tans very easily, olive or dark skin tone
☐ **Type VI**	Dark-skinned Black	Least Sensitive	Never burns, deeply pigmented, very dark skin tone

TOPICAL ANESTHETIC CONTRAINDICATED, (PLEASE CIRCLE THE YES ANSWERS).

1) Do you have an inflamed area of skin which could lead to excessive systemic absorption.
2) Do you have a history of allergic reactions to benzacaine, tetracaine or lidocaine.
3) Are you taking Class-I antiarrhythmic drugs
4) Do you have a history of congenital or idiopathic methemoglobinemia (blood Disorder).
5) Do you have a history of severe Liver disease.

HOW TOPICAL ANESTHETIC WILL BE APPLIED:

1) Remove makeup, using a cleanser suitable for the skin type.
2) Degrease the skin [optional].
3) Thoroughly dry the skin with clean gauze.
4) Apply a thin film of cream to the area which will be treated, using a cotton applicator or tongue .
5) Wait for 10-20 minutes for the cream to work.
6) Wipe off excess cream prior to treatment.
7) Advise the patient that numbness will persist for up to 3 hours and that he/she should avoid rubbing, self-scratching, or exposure to extreme hot or cold temperatures until complete sensation has returned.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

VIDA Skin Beauty Center

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

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the 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.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____

Physician's or Authorized Representative's Signature — Date

VIDA FAMILY PRACTICE PC, Dr. Vigen V. Abovian, MD
435 Arden Ave. Ste 330, Glendale CA 91203
Tel. 818-548-8001 Fax. 877-548-0506

Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____

Patient's or Patient Representative's Signature — Date

By: _____

Print Patient's Name

_____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

FINANCIAL POLICIES

Our staff members are specially trained in the financial options available to our patients, and they are ready to assist you with these issues in any way that you may require. Because we provide elective cosmetic procedures, the care provided at **VIDA SKIN BEAUTY CENTER** is not covered by any medical insurance programs, and we do not participate in any such plans.

PAYMENT OPTIONS

Payment for all medical spa procedures is due at the time of the treatment. For specially packaged or grouped treatments, payment for the entire package is due at the time of the first scheduled treatment. **A credit card is required to reserve an appointment for treatment scheduled in advance**. We provide a number of payment options which may be used individually or combined according to your desires:

CASH : cashier's check, or cash
MAJOR CREDIT CARDS: VISA, MasterCard, and American Express, other
CARE CREDIT: We can help you apply for credit line through **Care Credit** for financing medical procedures.

CANCELLATION AND REFUNDS

We understand that a situation may arise that could force you to cancel or postpone your treatment. Please understand that such changes affect not only our staff but our other patients as well, and we therefore request your courtesy and concern. If you need to cancel your appointment, please allow 24 hours to notify us of the cancellation. Should we receive less than 24 hours of notification, or should you fail to keep your appointment, your credit card will be charged **$100** for the visit.

INITIALS_____

THERE CAN BE NO REFUNDS FOR SERVICES ALREADY PROVIDED.

In the event that a package or series of treatments has begun, these services will be considered to have been rendered even though the full series may not have been completed. Should you wish to discontinue your treatment in the midst of a series, credit for the pro rata share of unused treatments at the discounted package price may be extended, and may be used for other treatments or products at **[VIDA SKIN BEAUTY CENTER]**, or it may be transferred to another individual to be used in exchange for treatments or products of comparable value to the credit.

INITIALS_____

REVISIONAL TREATMENT OR TREATMENT OF COMPLICATIONS

The practice of medicine and surgery is not an exact science, and medical spa treatments are the practice of medicine. Although good results are anticipated, **there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results you may get.** Occasionally additional treatments and/or treatment for problems or complications may be required. These could result in additional charges for which you may be responsible. Your insurance, if you have it, may or may not cover the expenses related to actual complications or other medically related problems arising out of treatment at **[VIDA SKIN BEAUT CENTER],** and I acknowledge that I have read and fully understand the foregoing Financial Policies and my obligations related there to this. These Financial Policies are subject to change without notice. If you have any questions or need assistance with any financial matters relating to your treatment, please contact our office for help.

INITIALS_____

_____ _____
Patient Signature Date

435 Arden Ave Suite 330, Glendale, CA 90203, Tel 818-548-8001 Fax 877-548-0506

OFFICE POLICES

Appointments
Scheduling an appointment means you are committed to following through with the time we have scheduled exclusively for you. Should you need to reschedule or cancel your appointment, we require a 24 hour notice. Providing our professional aesthetic services require a great deal of preparation, supplies, and scheduled time. Due to this, we do require a valid credit card at the time of reservation to ensure an adequate cancelation notice. If you provide us with less than a 24 hour reschedule or cancellation notice, or you may charged a $100 fee. If you arrive more than 15 minutes late for your scheduled appointment, we may need to reschedule your service for a different time or date as to keep the remainder of the following scheduled appointments on time for other guests. Please silence all cell phones at the time of arrival.

Patient/Client paperwork
Please arrive 15 minutes early for your initial service at our office to complete necessary forms and paperwork. Although it may seem like a lot of paperwork on your first visit, this is to ensure your health and safety as well as having a full understanding of needs or expectations from your treatments. All necessary forms must be completed in order to perform any service on you at our facility.

Payments
For your convenience, we accept the following forms of payment: Cash, Visa, Mastercard, Discover & Care Credit financing. Patients and clients are required to pay the full fee for services and goods are rendered unless a prepayment has been made. Some services require a deposit or prepayment in full at the time of booking.

Health Considerations
All patients and clients must be at least 18 years of age or older. Please notify us right away if you become pregnant, planning to become pregnant, or are breastfeeding as we may need to reschedule your treatment for your safety, or alter your at home skin care regimen. Please inform at the time of scheduling if you have a history of fever blisters. We may issue you a medication to take before treatment to prevent a flare-up of symptoms post treatment. We advise patients and clients about the treatments and products that are best suited for their individual needs. Your patient records, treatment plans and personal information are completely confidential.

Treatment Series Pricing
Some aesthetic services are recommended as a series for full benefit and are offered as a series at a reduced cost. All series are non-refundable, unless there is a medical reason you cannot complete treatment. If there is a non-medical reason you do not complete treatment, we will charge the full, non-discounted price for each completed treatment and credit your account with the unused balance. You may use this credit balance for any aesthetic service or product. If a series, package or special includes a free product, and the treatment is not completed, then the retail cost of the product will be deducted from any exchange due.

Gift Certificates / Expiration Dates
All gift certificates expire one year from the purchase date, unless specified otherwise. Any monthly specials and birthday offers are valid in the month advertised only. Gift certificates can be purchased for any denomination. They may be redeemed for services or products. Gift Certificates may not be refunded for cash.

Refund Policy
All sales and services are final; there are no refunds for services performed.

Signature _____ Date: _____

VIDA SKIN BEAUTY CENTER

PATIENTS' RIGHTS AND RESPONSIBILITES / CONSENT TO TREATMENT

VIDA Family Practice, PC., is dedicated to providing you with the best in health care. Along with technical expertise, we want to provide you a considerate and respectful care with positive patient experience. We respect your rights as a patient and want you to understand your responsibility as a partner in your care.

CONSENT TO TREATMENT

□ I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of the VIDA SKIN BEAUTY CENTER., its medical staff and their designees, as may in their professional judgment be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition or the condition of the person for whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

This consent to treatment may be revoked in writing at any time by the patient or duly authorized agent.

PATIENTS' RIGHTS

- You have the right to participate in the development and implementation of your plan of care.
- You will not be denied access to care due to race, creed, color, national origin, sex, age, sexual orientation, disability.
- You have the right to information about your diagnosis, condition and treatment, in terms that you can understand.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the possible consequences.
- You have the right to make or have a representative of your choice make informed decisions about your care.
- You have the right to formulate advance directives and have them followed.
- You have the right to appropriate assessment and management of pain.
- You are entitled to information about rules and regulations affecting your care or conduct.
- You have the right to know the names and professional titles of your physicians and caregivers.
- You have the right to personal privacy and to receive care in a safe environment.
- You have the right to a prompt and reasonable response to any request for services within the capacity of our clinic
- You have the right to express concerns or grievances regarding your care to the office.
- The confidentiality of your clinical and personal records will be maintained.
- You have the right to see your medical record within the limits of the law.
- You have the right to an explanation of all items on your bill.

PATIENTS' RESPONSIBILITES

- It is your responsibility to provide accurate and complete information about all matters pertaining to your health
- You are responsible for following the instructions and advice of your health care team.
- If you refuse treatment or do not follow the instructions or advice, you must accept the consequences of your actions.
- It is your responsibility to notify us if you do not understand information about your care and treatment.
- You are responsible for reporting changes in your condition or symptoms, to a member of the healthcare team.
- It is your responsibility to act in a considerate and cooperative manner and to respect the rights and property of others.
- You are responsible for following the rules and regulations of the health care facility.
- You are expected to keep your scheduled appointments or to cancel them in advance if at all possible.
- It is your responsibility to pay your bills or make some arrangement with the facility to meet your financial obligations.

I certify that I have read and understood the authorization to treatment given above, as well as the patients' rights and responsibilities specified in this agreement, and I accept its terms.

_____ _____

Date Signature of Patient or Designee and Relationship to Patient

AUTHORIZATION FOR MARKETING AND REALEASE OF YOUR: MEDICAL PHOTOGRAPHS /SLIDES/ VIDEOTAPES

1.) MARKETING AUTHORIZATION

According to federal law we must ask for your permission to send to you via email or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e. office promotions such as Botox events and/or other special discounts). Our office DOES NOT sell our patients names or other personal information. This authorization is effective until revoked in writing.

_____ Yes, I agree and give permission; **_____ No, I do not agree and don't give premission,**

to VIDA FAMILY PRACTICE, PC and VIDA SKIN BEAUTY CENTER to send me by (mail, email, or texting) any promotion or events as stated above.

Email: _____ Cell Phone:_____

Signature of Patient or Guaridan:_____ Date:_____

2.) CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize **[Vigen Vick Abovian, MD]**, Medical Director of **[Vida Skin Beauty Center]**, and/or his associates or licensees to take pre-procedural, and post-procedural photographs, slides, and/or videotapes.
I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation by **[Vigen Vick Abovian, MD]** and/or the staff of **[Vida Skin Beauty Center]**, and I understand that they shall be made a part of my medical record.

Signature of Patient or Guaridan:_____ Date:_____

3.) CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize **[Vigen Vick Abovian, MD]**, Medical Director of **[Vida Skin Beauty Center]**, and or his associates or licensees to use (pre-procedural, intra-procedural, and post-procedural) photographs, slides, and/or videotapes for professional medical or promotional purposes as deemed appropriate by them, including but not limited to display of these images on public or commercial television, electronic digital networks, scientific medical publications, lay publications, or during lectures to medical groups for the purposes of informing the medical community or the general public about aesthetic or medical treatment procedures available at **[Vida Skin Beauty Center]**. Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable.
I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and I hereby grant this consent as a voluntary contribution in the interest of medicale ducation. This permission may be revoked by me at any time to prohibit future use by direct written communication with **[Vigen Vick Abovian, MD] or [Vida Skin Beauty Center].**

Signature of Patient or Guaridan:_____ Date:_____

HIPPA INFORMATION AND CONSET FORM

VIDA Skin Beauty Center

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more comlete version may be obtained from our office staff.
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, _____ date_____ 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.

Signature _____ Date: _____

VIDA SKIN BEAUTY CENTER

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for VIDA FAMILY PRACTICE, PC. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by VIDA Family Practice, PC., describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. VIDA Family Practice, PC., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to privacy officer: Vigen Vick Abovian, MD. By signing this form, I am consenting to allow VIDA Family Practice, PC. to use and disclose my PHI to carry out TPO.

With this consent, VIDA Family Practice, PC., may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, and any calls pertaining to my clinical care, including laboratory test results, among others, and may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential." I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, VIDA Family Practice, PC., may decline to provide treatment to me.

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following way:

___Home phone ___Cell phone ___Work Phone

□ O.K. to leave message with detailed information
□ Leave message with call-back number only.

Home phone #: _____

Cell phone #: _____

Work Phone #: _____

□ Written Communication

□ O.K. to mail to my home address
□ O.K. to mail to my work/office address
□ O.K. to fax #_____

___ I AGREE NOT TO USE ANY EMAIL OR TEXTING COMMUNICTIONS FOR MY MEDICAL RECORDS OR HEALTHCARE QUESTIONS.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Name of Patient or Legal Guardian Date

PHOTOS /IMAGING - BEFORE PROCEDURE

PRECEDURE: _____ DATE: _____

CLIENT NAME: _____DOB: _____

PHOTOS TAKEN BY: _____ DATE: _____

SCALP

- ☐ Top
- ☐ Front
- ☐ Rear
- ☐ Left side view
- ☐ Right side view

FOREHEAD

- ☐ Front straight
- ☐ Front, turned Right 90 degrees
- ☐ Front, turned Left 90 degrees

FACE

- ☐ Front straight
- ☐ Front , turned Right 90 degrees
- ☐ Front turned Left 90 degrees

NECK

- ☐ Front
- ☐ Left side view
- ☐ Right side view
- ☐ Inferior

BODY

- ☐ Front
- ☐ Left side view
- ☐ Right side view

LEGS / THIGHS / BUTTOCKS

- ☐ Front
- ☐ Left side view
- ☐ Right side view

HANDS

- ☐ Front
- ☐ Left side view
- ☐ Right side view

OTHER AREAS: _____

- ☐ Top
- ☐ Front
- ☐ Rear
- ☐ Left side view
- ☐ Right side view
- ☐ Right side at 90 degrees
- ☐ Left side at 90 degree