Vernillo Health & Wellness

General Consent

In our ongoing efforts to provide you with the best possible service, we ask that you carefully review this consent form and ask any questions necessary to help you fully understand it. Please sign at the bottom only after careful review and consideration.

Wellness Center- I understand that during the course of my wellness treatments at the office a medical condition may be diagnosed. I understand that this office does not treat chronic diseases and that if a chronic or acute disease is discovered I will seek immediate care with my primary care physician or local urgent care center. A copy of chart will be provided at no extra charge. We do not provide after hours emergency care or answering service. We do not prescribe controlled substances in this office.

Disclosure of Medical History- I agree that I will disclose a full and accurate personal medical history, including any and all information regarding medical conditions and my use of medications, drugs, herbs, vitamins or other supplements of any kind. I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of complications. Pharmacy history will be pulled electronically on all patients.

Confidentiality- I understand that no information regarding services performed shall be released without my express consent except as follows: I authorize that copies of my records may be sent to another location if I seek additional treatment at that location. I understand that, in addition to authorized clinic personnel, the clinic's medical director and consulting physicians shall have full access to my treatment records. I understand that appropriate medical review may be conducted to further the safety and efficacy of my practitioner's services. I understand my practitioner may also provide limited patient information to various third-party vendors to provide database development and maintenance services, referral services or marketing research services. I understand that photographs may be taken to document treatment results, but they will not be released or used otherwise without my specific written consent. My practitioner will maintain file copies of all records for a minimum of three years.

Skin Care Products- I understand that some of the skin care products offered by my practitioner are professional strength and formulated to aggressively treat problem skin. I agree that I will use any skin care products obtained from the clinic in accordance with the instructions and directions provided to me by the clinic staff and only after becoming acquainted with the product and its recommended use. I realize that I may experience varying degrees of discomfort, redness, burning, peeling, itching, dryness or other symptoms, especially in the early stages of use. These symptoms should lessen and eventually subside as my skin tolerance develops. I understand that in unusual circumstances, use of these professional strength products could be harmful and even cause injury to the skin (infection, discoloration, superficial scarring, etc.). I will discontinue use and notify my practitioner if any unusual or concerning irritation occurs. I will not use any of these professional strength products if I am nursing, pregnant or trying to become pregnant. I understand that long-term use is necessary to achieve and retain the desired benefits.

Continued Consent- I understand that my practitioner's services generally consist of a series of treatment to achieve maximum benefit, and this consent shall apply to all services rendered to me by my practitioner, including ongoing or intermittent treatments. This consent is also authorization to bill insurance for reimbursement if feasible.

Cancellation Policy- I agree to contact my practitioner at least 48 hours in advance if I need to cancel or reschedule my appointment. I understand that I may be required to pay a missed appointment fee. I understand that if I arrive more than 15 minutes late for my appointment I may be required to reschedule to avoid disrupting the appointments of other patients. Please see specific cancellation policy form for further details.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, _____ HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature (if patient under 18) Date