COSMETIC INTEREST QUESTIONNAIRE

CONTACT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PH: _____ CELL: _____ E-MAIL: _____

For the following statements, please circle the number that best reflects your opinion, with 1 as agreeing the least and 5 as agreeing the most.

Which phrase best describes your skin type?

__ I- always burns, never tans
__ II-always burns, sometimes tans
__ III- sometimes burns, always tans
__ IV- rarely burns, always tans
__ V- moderately pigmented (Hispanic, Asian, Mediterranean, Middle Eastern)
__ VI African American

1. If effective, non-surgical options were available to successfully correct my lines and wrinkles, I would be interested. __yes __no
2. Do you have a history of keloids or unusual scarring? __ yes __ no
3. Do you have a history of Herpes simplex (fever blisters, cold sores) recurring in the area to be treated? __ yes __ no
4. Have you been on Accutane (isotretinoin) in the last six months? __ yes __ no
5. Do you use Retin-A, Renova, Differin, glycolic acid products or hydroquinone (bleaching agent) on the treated area? __ yes __ no
6. Have you had waxing, plucking or electrolysis performed on the area(s) to be treated in the preceding six weeks? __ yes __ no
7. When were you last exposed to the sun (including tanning booths)? _____
8. Do you use sunless tanning lotions? __ yes __ no When was it last applied? _____
9. Are you pregnant? __ yes __ no
10. Please list any medications, including hormones, you are currently taking:
    _____
11. Please list any medication allergies: _____
12. Have you ever had permanent make-up (eyeliner, lip liner, blush, eyebrow color)? __ yes __ no If so where? _____
13. Do you have any tattoos (medical, cosmetic, decorative, or traumatic) in the area to be treated? __ yes __ no If so where? _____
14. Have you ever been checked for hormone, thyroid problems or have you ever been seen by an endocrinologist? __ yes __ no
15. What products are you currently using on your skin in the area you wish to be treated?
    _____
16. Have you ever had a cosmetic laser treatment or laser hair removal? If so what type and when?
    _____
17. Do you have Lupus? ___ yes ___ no

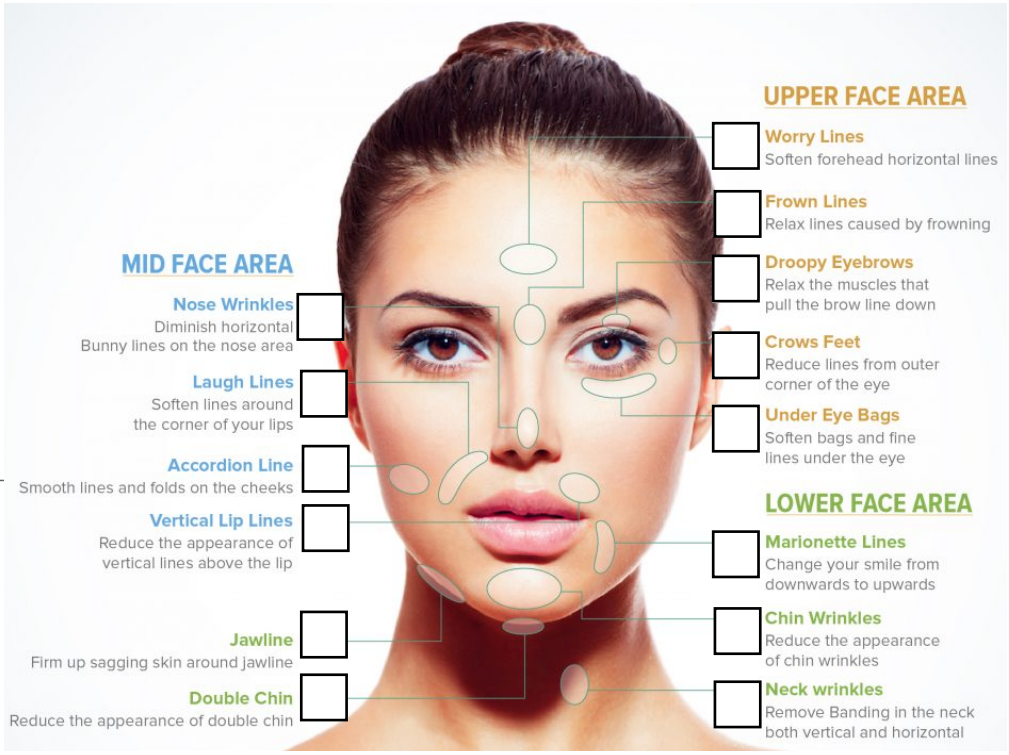
CONSULTATION AND TREATMENT PLAN

AREAS OF INTEREST: Sometimes the best results can be achieved by using multiple treatment methods regarding areas of concern. Radiance, clarity and smooth texture are the hallmarks of youthful skin, though over time, the effects of aging and sun exposure can take their toll. They result in skin imperfections such as wrinkles, fine lines, sunspots, uneven skin tone and skin laxity.

(PLEASE CHECK ALL AREAS OF CONCERN & YOUR INTERESTS)

Treatment Options:

- ○ Skin-care Analysis or Consultation
- ○ Skin Rejuvenation, Tightening & Lifting
- ○ Skin Resurfacing
- ○ Acne Treatment Reduction
- ○ Nail Fungus Removal
- ○ Psoriasis Treatment
- ○ Birthmark Correction
- ○ Hyperpigmentation/ Spot Correction
- ○ Hair Removal
- ○ Scar & Stretch Mark Reduction
- ○ Other (Please Specify): _____



I _____, have chosen the following treatments listed.

- ○ Skin Remodeling & Rejuvenation with *ClearLift Q-Switch Laser*
- ○ Vascular Lesions with our Erbium *YAG Laser*
- ○ Pigmented Lesions with *ClearLift Q-Switch Laser DYE VL Laser*
- ○ Skin Resurfacing (Tone and Texture) with *iErbium YAG Laser*
- ○ Hair Removal-*with SHR Method*
- ○ Acne Treatment with *ClearLift Q-Switch Laser*
- ○ Toe Fungus Treatment with *Erbium YAG Laser*
- ○ *Scar & Stretch Mark Reduction with Erbium YAG Laser & ClearLift Q-Switch Laser*
- ○ *Psoriasis Treatment with Erbium YAG Laser & ClearLift Q-Switch Laser*

The Skin Evaluation and Consultation Form reflect the chosen areas I wish to receive my treatment. ___*Initial*

FOLLOW-UP TREATMENT PLAN:

- ○ Patients should return in _____, for additional treatment, if necessary. Treatment intervals: 2-4 week intervals.
- ○ Treatment is complete when *satisfactory results are obtained.*

POST CARE INSTRUCTIONS:

- ○ *Patients should be instructed to avoid sun exposure after and in between treatments.*
- ○ *Apply Aquaphor to Treated Area twice a day for 2 days.*
- ○ *If treated by the Erbium YAG Laser apply aloe gel to treated area.*
- ○ *Use a mild soap and cool water when cleansing the treated area.*
- ○ *If treated by the Erbium YAG Laser, do not apply makeup for at least 2-4 days after treatment.*
- ○ *Apply your moisturizer every day*
- ○ *Stay hydrated by drinking penty of water.*
- ○ *Do not use any other creams or ointments (such as bleaching creams, Retin-A, or glycolic acid)*
- ○ *If treated by the Erbium YAG Laser do not use any alcohol based products.*

TOTAL TREATMENTS RECOMMENDED: _____

Patient name (printed) _____ Date: ____/____/_____

Patient Signature: _____

INFORMED CONSENT FOR LASER THERAPY - LIABILITY WAIVER AND RELEASE

I _____, understand that a **LASER** is being used for my treatment. Although laser therapy is safe and effective in the majority of cases, unexpected adverse events may occur. Unexpected side effects may result from the use of the laser & the expected response of the treated area may not be achieved.

- **To Provide Treatment:** We will use your HPI within the office to provide you medical treatments. This may include administrative, clinical and office procedures designed to optimize scheduling/coordination of care between the physician and/ or staff handling your care.
- **To Obtain Payment:** We will use your HPI with an invoice, used to collect payment for the treatment you receive here. HPI will be used on Credit Applications or Other Third Party Financing forms sent by mail or electronically.
- **In Patient Reminders:** Phone calls to remind you of a upcoming appointment or situations will be necessary. Additionally, we may also use electronic methods to contact you such as email, text message, by phone, online patient accounts, postcards, letters, statements, etc. These methods of communications help optimize our office workflow.
- **Short term effects:** I understand that there are multiple short term effects that may occur, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, blistering, scabbing, crusting, flaking & sensitivity to the sun. Although these effects typically resolve within several days, they may persist for several weeks and rarely, even longer. I understand that the degree of the side effects varies from person to person, and it may not be possible to predict how I will respond.
- **Possible permanent effects:** I understand that although most side effects are short term and resolve fairly quickly, some effects may be permanent. Scarring, changes in pigmentation & hair loss may be permanent.
- **Discomfort associated with procedure:** I understand that the laser functions by heating up its target (blood vessels, pigmentation). This heating sensation is minimized by the use of the cooling piece, but some level of discomfort may be felt. The level of discomfort depends on the treatment being done, and varies from person to person. The stinging or sensation of heat is typically short but may persist for several hours after the procedure.
- **Effects of UV:** I understand that sun exposure, tanning beds, sunless tanning lotions, and tanning creams can cause discoloration or reaction to laser treatment during and after the procedure. Having any kind of tan prior to therapy or soon after therapy results in an increased chance of blistering, permanent or temporary discoloration, scarring, and discomfort. I understand that avoidance of any UV exposure 1 month prior and 2 weeks after treatment reduces the risk of these effects.
- **People excluded from therapy:** I understand that certain patients should not have laser treatment. This includes any patients who have open wounds, malignant skin tumors, patients who have certain disease that make them sensitive to light, patients currently on Accutane (Isotretinoin) or who have been on Accutane within in the last 3 months and patients who have tattoos.
- **Need for multiple treatments:** I understand that some conditions being treated by the laser may require multiple treatments to obtain the desired results. Everyone responds in different ways and different rates to the treatment.
- **Photographs:** I understand photos or video of my treatment may be taken. These may be used for teaching health professionals or shown for scientific reasons. I will NOT be identified in any photo or video.
- **For laser vein treatment:** I understand that this procedure involves a laser to coagulate the vessels and a bruising effect could last up to 6 months. It is possible the results will be minimal or not help at all. I realize that each individual's treatment response is different; therefore it could require multiple treatments to achieve desired results.
- **I agree to wear proper eyewear.** Eye injury due to use of the laser is a risk to the patient.
- **I understand that this procedure is elective & there are other options for treatment including no treatment.**
- I understand that my insurance company will **not** cover the cost of laser therapy, and I am responsible for the complete cost of the service.
- **Cancellations:** We request the courtesy of a 24-hour notice in the event an appointment needs to be canceled or rescheduled. A $30 no-show fee for Laser will apply in the event that an advanced cancellation notice is not given.
  FINACIAL RESPONSIBILITY-Any fees agreed to, are due upon time before the first treatment is rendered:
  For Non Credit Applicants, we require payment in full in order to schedule your treatments. We accept Cash, Visa, Mastercard, Visa, American Express and Discover.
- **Limited Guarantees:** Because all individuals are different, it is not possible to completely predict the benefits from the laser treatment. Limited guarantees can be made concerning the results of the treatment. Some patients will have a very noticeable improvement, while other may have little or minimal improvement. Optimal results are achieved by completing a series of treatments, as you will probably not see results after only one treatment.
- **Lack of Permanent Results:** Treatments may vary among patients. For some this may mean a significant decrease in the frequency with which you may continue other daily regimens. For others it may mean better cosmetic improvement because of combination of treatments used., If HAIR REMOVAL- Everyone will experience hair regrowth over time, regardless of the technology used. Hair that grows back will tend to be finer, lighter and less dense.

Dr. Curtis Story MD has explained the nature and purpose of the laser treatment, including any risks and possible complications. The contents of this form has been discussed and explained to me. I have read and understand this consent form & I agree to its terms and authorize treatment. I do hereby waive, release, absolve, indemnify and agree to hold harmless Dr. Curtis Story MD for my individual treatment results. I further understand that results CANNOT be guaranteed.

Patient Name (PRINTED) _____ **Date:** _____

Patient Signature: _____

STORY FAMILY MEDICINE

LASER TREATMENT PAYMENT AND DEPOSIT AGGREEMENT

NAME:_____DOB: __/__/____

Phone: _____

Email: _____

TOTAL PRICE OF TREATMENT: _____

TODAY'S DEPOSIT: _____

BALANCE DUE DAY OF APPT: _____

PLEASE NOTE:

A payment is required at the time your appointment is scheduled. Your Consultant will quote the **non- refundable** deposit price during your consultation.

Any cancellation or changes to an appointment must be made **12 hours** prior to the scheduled appointment. You will be charged a No-Show fee in the amount of $30 after the 2nd missed appt.

Please follow the care instructions provided to you to ensure satisfactory results.

Appointment Date: ___/___/_____

Appointment Time: _____

Length of Appointment: _____

METHOD OF PAYMENT:

___Cash ___Credit Card ___CareCredit

Last 4 of the CareCredit Account #_____

CC#:.....

Ex: Date: __/__/____Security Code: _____

I have read, initialed, and understand the LaserTreatment Questionnaire, Home Care Instructions, Consent and the Deposit Agreement.

_____

Client Signature

_____

Consultant Signature

Date: ___/___/_____

WRITTEN FINANCIAL POLICY

PAYMENT OPTIONS:

Our office accepts: - *Cash, Visa®, MasterCard® or Discover Card and Care Credit*

- We offer a 20% courtesy accounting adjustment to patients who pay for their treatment with Cash/check/debit prior to completion of care for treatment plans of 600 or more.
- *Story Family Medicine LLC* requires payment prior to the appointment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.
- We accept payment in thirds. For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of $500 or more, a $100 deposit is required to secure your initial treatrnent appointment.
- We also offer in-house financing with Care Credit over $300. We charge based on promotional agreement with % interest on all past due accounts.
- A fee of $25 is charged for patients who miss or cancel more than 3 times in a calendar year without 12 hour(s) notice.
- Story Family Medicine LLC charges $30 for returned checks.

If you have questions about your vision care or the choice of payment options, please do not hesitate to ask. We are here to help you get the quality care you want or need.

As you know, it is this practice's policy to receive payment At time of service. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. You have agreed to pay your patient portion of the treatment fee in the following

FOR STAFF ONLY:

(Recommendations and discussions with provider)

- **COSMETIC QUESTIONAIRE**
- **CLIENT CONSENTS**
- **CLIENT EXPECTATION, CONSULTATION & TREATMENT PLAN:** (understands need for multiple treatments, after care, possible side effects, etc.) Importance of sun exposure avoidance and the use of a broad-spectrum zinc oxide or titanium dioxide
- **FULL TREATMENT SCHEDULE PROCESS** (waiting period in-between treatments, expected results., etc.
- **POSSIBLE SIDE EFFECTS** (Waiver of Liability) (hyperpigmentation, hypopigmentation, purpura, scarring, textural changes, burns, blistering, pain or discomfort and erythema) and length of time to expect healing if side effects occur.
- **SKIN TEST:** Specifics of area to be treated. Test small area for tissue response BEFORE full treatment.
- **CLIENT COMFORT:** Note sensation of the laser/DCD spray and the option for topical anesthesia or other cooling methods.
- **BENEFITS:** Benefits of laser treatment (long-term hair removal), improvement in skin, etc.
- **COST OF TREATMENT** (Payment Plan, Cost of multiple treatments versus single payment per visit).
- **PATIENT SAFETY:** Eyewear protection and laser safety measures required for patient and provider. Patients may sense light while wearing proper eye protection. Patient must verbalize sensation during treatment.
- **CLIENT MATERIALS:** Importance of post care instructions/procedures.

  (Patient given copies of treatment plan).

  PHOTO TAKEN TODAY: _____ YES _____NO

  COMMENTS: _____