North Valley Medical Center

7301 E Sundance Trail Suite C-102
Carefree, AZ 85377
Office 480.473.4583 Fax 480.595.3262

CONTACT INFORMATION

Name: _____ Age: _____ DOB: _____Male:_____Female:_____

Home #: _____ Cell #: _____ Email:_____

Address: _____ City, State, Zip:_____

Employer: _____Occupation:_____

EMERGENCY CONTACT: Name: _____ Relationship: _____ Phone #: _____

Who is your PCP? Name:_____ Phone: _____ Fax: _____

Do you have any Drug or Food allergies? If yes, please list them:

_____

LIST YOUR COSMETIC CONCERNS IN ORDER OF IMPORTANCE

1) _____
2) _____
3) _____
_____

List All Cosmetic Surgeries and/or Recent Procedures, including date occurred:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

Medications: 1: _____ 2: _____ 3: _____

4: _____ 5: _____ 6: _____

~Your satisfaction is very important to us, Dr. McNeil likes to check in 2-3 weeks following your treatment. What is your preferred method of communication?

_____

Please tell us who to thank for referring you to us? _____

Is it ok for NVMC to contact you via email 1-2x per month for special offers and discounts? Y N

We will never share your information with a third party

Review of Systems:

Regarding the next section: Please circle (Y) if you have the problem NOW, (N) if you've NEVER had the problem, (P) if you've had the problem in the PAST. Please use the space below to explain Y and P answers.

Rashes:	**Y N P**		**Color Change:**	**Y N P**
Hives:	**Y N P**		**Lumps:**	**Y N P**
Psoriasis:	**Y N P**		**Itchy skin:**	**Y N P**
Dry skin:	**Y N P**		**Warts/Moles:**	**Y N P**
Cancer:	**Y N P**		**Acne:**	**Y N P**
Headache:	**Y N P**		**Paralysis:**	**Y N P**
Low Blood Pressure:	**Y N P**		**High Blood Pressure:**	**Y N P**
Easy Bruising:	**Y N P**		**Cold Sores:**	**Y N P**
Muscle Weakness:	**Y N P**		**Fainting:**	**Y N P**
Heart Problems:	**Y N P**		**Seizures:**	**Y N P**

_____

_____

- ✓ I understand that any expenses incurred with North Valley Medical Center for myself or any of my minor dependants are my responsibility and not that of any other person or insurance group.
- ✓ I understand that payment is due in full at the time of service.
- ✓ I understand that I will be billed for any appointment missed or changed with less than 24hours notice.
- ✓ I understand that no claims or guarantees have been made by North Valley Medical Center for future insurance reimbursement or particular medical outcomes.
- ✓ I understand that not all treatments or products used by North Valley Medical Center are FDA approved.
- ✓ I understand that all information given to North Valley Medical Center now or at any point in the future is entirely confidential. It is NVMC's policy to follow HIPAA guidelines and NVMC requires a signed medical release form before releasing medical records to anyone other than myself unless legally required to do so. I may choose to keep a release form on file to expedite the handling of my records.
- ✓ My signature below gives North Valley Medical Center my permission to fax medical records to myself at a fax number given to NVMC by myself without a signed consent.
- ✓ At times, e-mail or fax may be the best option to communicate confidential medical information between myself and my doctor. I understand these are not secure forms of communication and my records will not be protected when using these forms of communication.

Signature of Patient or Legal Guardian of Patient **Date**

INFORMED CONSENT

This form is designed to present benefits and risks of the therapies offered by North Valley Medical Center and *must be signed* before treatment is rendered. *Ask your doctor if you have any questions or concerns regarding your consent to treat prior to signing this Informed Consent form.* **Treatments, procedures and/or products used in your treatment at North Valley Medical Center may or may not be FDA approved and might be an off label use of an FDA approved product.**

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with post treatment instructions will increase the effectiveness of my procedure and enhance or maintain the results.

I understand that Dr. Mcneil uses diagnostic and treatment methods that are known as investigational, complementary, alternative, and/or off-label. Some of these methods have not been accepted by consensus mainstream medicine or the FDA.

I do not expect the doctor to be able to anticipate and explain all the risks and complications that could possibly happen during or because of treatment and I wish to rely on the doctor to be able to exercise judgment during the course of the procedure based upon the facts known at that time.

I understand and am informed that, as in the practice of aesthetic medicine there are some risks.

Some of the potential side effects to treatments and therapies are but are not limited to:

- Bruising
- Local Tenderness
- Redness and Swelling
- Allergy
- Drug Side-effects
- Fainting
- Infection

Please inform your doctor of any medication change or if there is a possibility of pregnancy at any time during your treatment and before future treatments.

Patient Rights

- You have the right to be treated with courtesy, respect and dignity.
- You have the right to know the process through which services are offered, including the general course of treatment, and with whom you will be working.
- You have the right to full confidentiality. All transactions and records within this office are kept strictly confidential. Your records may be released to other parties only when requested in writing by you, or when required by law.
- You have access and may request copies of your information at any time.
- You have the right to know and understand the practitioner's assessments and recommendations. These will be given to you at each visit including therapeutic goals, success of treatment, and proposed duration of treatment. If this is unclear please ask.
- If a medication is prescribed, or any other specific treatment is recommended, you have the right to know what the medication or treatment is, why it is being prescribed, what is the expected outcome, and general side effects which might be reasonably expected. Please ask your physician to explain prior to treatment.
- You have the right to access other community services and also the right to select and change practitioners. If you are interested in other practitioners or therapeutic modalities, please ask.
- You have the right to refuse service.
- You have the right to assert your rights as described within this document at any time without retaliation or fear of negative consequence.
- You as a patient have the right to full knowledge of fees.
- You have the right to know of any changes to services or charges and you will be notified.

I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatments and understand the risks and benefits involved.

Signature of Patient or Legal Guardian of Patient **Date**