Electrolysis Center
8077 Florence Ave, Suite 203A
Downey, CA 90240
(562) 343-6749

Electrolysis Center
9649 Lakewood Blvd
Downey, CA 90240
(562) 417-7449

Client Health History Assessment

Client Number:
electrolysis office use only

Primary Information

Today's Date: MM / DD / YYYY Date of Birth: MM / DD / YYYY

Legal First Name: _____ Middle Initial: _____ Legal Last Name: _____

Preferred Name: _____ Gender Identified as: _____

Street Address: _____ City: _____ State: _____ Zipcode: _____

Phone: **home / mobile** (____) _____ Email: _____

How can we contact you for appointment changes & reminders? {circle all that appply} Call / Text / Email

Emergency Contact Name: _____ Phone: (____) _____ Relationship: _____

Hair Removal Information

Areas you are considering for treatment? {circle all that apply}

Head: Lip / Mustache Chin Beard Eyebrows Unibrow Ears {outside} Sideburns Hairline Neck

Body: Armpits Breast / Chest Navel / Happy Trail Bikini / Groin Anus Penis Shaft Upper Back Lower Back

Limbs: Shoulders Upper Arms Lower Arms Hands Fingers Outer Thighs Inner Thighs Lower Legs Feet Toes

Other: _____

Hair Removal Methods

What hair removal methods do you most frequently use? {circle all that apply}

	Waxing	Sugaring	Tweezing	Creams	Laser	Threading	Other:
Frequency	____ times	____ times	____ times	____ times	____ times	____ times	_____ times
per	day/wk/mth	day/wk/mth	day/wk/mth	day/wk/mth	day/wk/mth	day/wk/mth	per day/wk/mth

Have you ever had electrolysis before? yes / no Electrologist's name: _____ location: _____

Date of last treatment: _____ Body part(s) treated: _____

Total # of treatments: _____ Modality: {circle all that apply} Thermolysis Blend Galvanic Not Sure

Skin reactions to any previous hair removal methods? {circle all that apply}

None Redness Swelling Ingrown Hair Infection Bumps/Pimples Other: _____

Other Information

How did you hear about us? Website Facebook Instagram Pinterest Google Referral ... who? _____

Other: _____

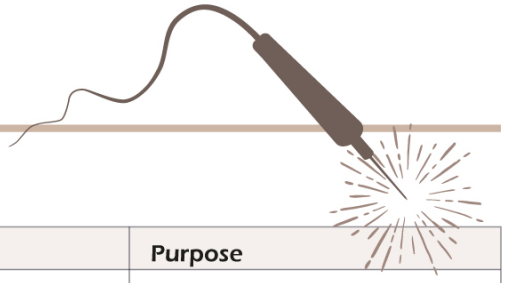
Media Release

Do we have permission to document your hair removal process through your story, pictures and or videos and use them in our company's print and/or digital publications? **Photographs:** yes / no **Videos:** yes / no **Initials:** _____

Client Comments & Questions: _____

Continue to other side →

Client Health History Assessment



Health Information

List All Medications & Vitamins You are Currently Taking:

Name	Purpose	Name	Purpose

List All Allergies:

Name	Comments	Name	Comments

Health Conditions Present or Past: {circle all that apply}

Acne Body Piercings Beathing Problems Cancer Cardiovascular Disease Clotting Issues Cold Sores COPD Diabetes Dizziness / Fainting Heart Attack Healing Issues Hepatitus Herpes High Blood Pressure HIV Infertility Metal Implants Keloids Kidney Disease Pacemaker Piercings PCOS TB Thyroid Disease Skin Tags Stroke Warts

Other: _____

Dermabrasion: yes / no **Last application:** MM / DD / YYYY

Are you pregnant: yes / no **Do you get your period:** yes / no **If yes, is it regular:** yes / no

Have you traveled outside of the country in the last 30 days: yes / no **Where:** _____

Have you had any major surgeries? yes / no **Specify:** _____

Are you preparring for sex reassignment surgery? yes / no **Planned Date of Surgery:** MM / DD / YYYY

Physician's Name: _____ **Phone:** ( ) _____

Physician's Location: _____ **May we contact to discuss your treatment plan:** yes / no

Client Acknowledgement of Information

I understand health history information is important to my Electrologist in order to provide me with safe and effective electrology treatments. I acknowledge all information given by me is accurate to the best of my knowledge, and I agree to update my health history assessment whenever there are changes. _____ Initials

I understand that a series of treatments is necessary to achieve permanent hair removal and my progress will be impacted by my personal hair growth rate, the science of electrology, and my individual physiological factors. _____ Initials

I have been advised of the post-treatment care, the healing process and the possible risks related to treatment. I agree to follow all aftercare instructions and to notify my Electrologist of any concerns or difficulty in healing. _____ Initials

I understand my electrologist has the right to refuse treatment if it is not beneficial to my health or skincare due to known or unknown health conditions I may have. _____ Initials

Client Name: _____ Signature: _____ Date: MM / DD / YYYY

If under 18, parent/guardian must sign.

Parent's Name: _____ Parent's Signature: _____ Date: MM / DD / YYYY

ELECTROLYSIS CENTER
PATIENT CODE OF CONDUCT

In an effort to provide a safe and healthy environment for staff, visitors and patients, the Electrolysis Center expects visitors and patients to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

- **If your insurance changes and you do not inform us, you will be responsible for the full cost of each service that has been denied by your prior health insurance.**
- Appointments are scheduled subject to electrologist availability.
- You will adhere to the treatment plan as discussed during your first appointment (consultation). Frequent cancellations will cause removal from our services, to allow other patients following their treatment plan an opportunity to get appointments.
- Arriving later than 15 minutes of your scheduled appointment time will be considered a no show and will not receive any treatment. At the discretion of the electrologist and/or owner, they will see you and your time missed will be deducted from your appointment.
- Two (2) or more missed/no show appointments will be removed from our services.
- Respect a patient's right to privacy, which is protected by Federal law
- Any communication outside of business hours will not be replied to until the next business day. Cancelling appointments can be done through the website unless you are giving less than 24-hour notice, then sending a text will be accepted but not confirmed until the next business day.
- Treatments will not be restricted, limited or denied on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability

You will agree to maintain a mutually respectful and courteous relationship between the Electrolysis Center staff and yourself. Our staff is dedicated to providing the highest quality of care to our patients. Violators are subject to removal from the facility and/or discharge from the practice. Thank you for your cooperation.

Acknowledgement:

_____	_____	_____
Patient Name	Patient Signature	Date

ELECTROLYSIS CENTER

OFFICE POLICY

Payment

Payment is expected at the time of services. You will be billed for the appointment time that was scheduled. We accept all major credit cards, debit cards, including FSA, HSA payments, cash, Venmo & Zelle. There is a $3 surcharge on all credit, debit and FSA & HAS cards.

Cancellations

We request that you give at least 24 hour notice for 1 hour or shorter appointment and at least 48 hour notice for over 1 hour appointments. This time is reserved exclusively for you and we would like to be able to fill it if you cannot make it to your appointment. Appointments NOT cancelled at least 24/48 hour notice a minimum of $40 or 50% of your appointment fee (whichever is higher) will be charged to your credit card on file and/or billed on your next appointment.

If an emergency happens and you have to cancel less than 24/48 hours, we understand. If it becomes a regular problem or if you do not call or show up for your appointment more than twice in a one-year period, you will have to pre-pay to get an appointment and forfeit the payment if you do not show up for your appointment without adequate notice.

All Saturday and Sunday appointments will be charged a missed appointment fee if you do not show up or cancel with less than 24/48 hour notice.*

If you have symptoms of COVID-19 or if you have been in close contact with someone that is positive, please reschedule your appointment as soon as possible. COVID related cancellations are exempt from our policies as long as you do not abuse them.

*Insurance patients with two (2) or more missed/no show appointments will be removed from our services.

Late Arrivals

Each time slot is reserved for the person in it. If you arrive late, we will try to accommodate your full appointment, however, if we cannot do so your time will be shortened accordingly. Since the missed time is time that we could not allocate to another person, we reserve the right to charge the price of your full appointment.

I have read the above information and understand the above office policy.

_____ _____ _____

Name Signature Date

Electrolysis Center

9649 Lakewood Blvd, Downey CA 90240
8077 Florence Ave, Suite 203A, Downey CA 90240

HIPAA & Notice of Privacy Practices

PATIENT DETAILS

First Name **Middle Name** **Last Name**

Date of Birth

Gender Identified as: **Marital Status**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

WE CONSIDER THE PRIVACY OF YOUR HEALTH INFORMATION OF PARAMOUNT IMPORTANCE.

OUR LEGAL DUTY

As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: https://www.hhs.gov/hipaa/for-individuals/index.html. We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will make commercially reasonable efforts to change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree in writing that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, concerning your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will (1) disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other

national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

PATIENT RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6years. We will provide such a list at no charge upon your request once in any 12 month period. We reserve the right to charge you for requests in excess of one per 12 month period.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Any such request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon your request.

QUESTIONS AND COMPLAINTS

To learn more about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

If patient is a minor,

Guardian's relationship to patient:

Address:

City: **State:** **Zip Code:**

***By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices**

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

- Updated: 3/31/2021 Rev:02