CHENEROLOGY

NAME:_____ DATE:_____

PRONOUNS:_____

PHONE NUMBER:_____

EMAIL:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH:_____

INSURANCE NAME:_____

POLICY #:_____

OHP#:_____

ANY OTHER NAMES USED:_____

EMERGENCY CONTACT

NAME:_____

CONTACT NUMBER:_____

CONTACT RELATION:_____

PLEASE TELL ME HOW CAN I HELP? _____

WHAT DO YOU CONSIDER YOUR PROBLEM AREAS?_____

_____

ALLERGIES:_____

MEDICATIONS:_____

SPECIAL CONSIDERATIONS:_____

HOW DID YOU FIND CHENERY or CHENEROLOGY ?

_____

Chenerology Electrology

CLIENT HISTORY FORM

Name:_____ **Today's Date:**_____

Hair Removal & You

1. Have you had electrolysis hair removal in the past?_____Dates:_____Yes No

What areas were treated?_____Was it successful?_____

Did you have any skin reactions?_____Where were you treated?_____

2. Have you had any of the following hair removal treatments in the last 6 months?_____ Yes. No

Bleaching Frequency:_____Last Used:_____

Tweezing Frequency:_____Last Used:_____

Waxing Frequency:_____Last Used:_____

Cutting Frequency:_____Last Used:_____

Threading Frequency:_____Last Used:_____

Shaving Frequency:_____Last Used:_____

Depilatory Frequency:_____Last used:_____

Your Body & Skin

1. Do you have any of the following skin disorders?_____Yes No

Acne Eczema Dermatitis Psoriasis Lipomas Rashes Keloids Lupus Vitiligo Hives Petechiae Cancer Other

If yes, please explain:_____

2. Are you prone to any of the following skin irritations?_____Yes No

Swelling. Itching. Dryness Oiliness Pigment Changes Other

If yes, please explain:_____

3. Do you have any allergies? (Latex, Topical Creams, ect.)_____Yes No

If yes, please explain:_____

4. Have you ever had problems with your skin healing?_____ Yes No

If yes, please explain:_____

5. Have you ever had sensitivity to sunlight?_____Yes No

If yes, please explain:_____

6. Have you been treated for of the following medical conditions?

Heart Problems High Blood Pressure Diabetes Hemophilia Circulatory Problems Cancer Tuberculosis Herpes Epilepsy HIV Hepatitis Nerve Disorder Tumors

If yes, please explain:_____

_____

Chenerology Electrology

Chenerology Client Questionnaire Form

Medications

1. Are you currently using or have ever used Retina? Dates:_____ Yes No
2. Are you currently using or have ever used Accutane? Dates:_____ Yes No
3. Are you currently using or have ever used Rambazole? Dates:_____ Yes No
4. Are you currently using any other Medication?_____ Yes No

If yes please explain: _____

Hormone Balance

5. Is your hormone function normal?_____ Yes No

If no, please explain_____

6. Have you experienced rapid changes in your weight or voice?_____ Yes No

If yes, please explain: _____

7. Have you ever talked to your physician about your hair growth?_____ Yes No

If yes, please explain: _____

8. Are you familiar with PCOS? _____ Yes No

For Women

9. How often is your menstrual cycle?_____
10. Was your last gynecology exam normal?_____ Yes No

When was it? _____If no please explain:_____

11. Do you take birth control pills?_____ Yes No

If yes, when and why did you start?_____

12. Are you currently pregnant or trying to get pregnant?_____ Yes No
13. Are you post-menopausal? _____ Yes No
14. Have you had a hysterectomy?_____When:_____ Yes No
15. Have you had your ovaries removed?_____When:_____ Yes No
16. Have you ever had ovarian cysts? _____Dates_____ Yes No

I certify that the information I have provided is accurate and complete to the best of my knowledge. I understand that it is my obligation to notify Chenerology of any changes as it is critical to my treatment.

Client Name:_____ **Date:**_____

Client Signature:_____

Chenerology

Chenerology Office Policy

The nature of our business requires personal attention to our clients. Appointments are set to ensure that we may provide the best care to each individual and ensure satisfaction on every visit. Late arrivals may reduce the length of treatment possibly cause you to forfeit the entire time slot to properly accommodate the next client. In order to maintain these standards, please arrive a few minutes prior to your visit. We know life is hectic sometimes - if you will be running late, contact me by phone (503-320-5380) so I will have the opportunity to happily work with you. I try not to book back to back clients so that a schedule can be kept. WE need to pay attention that some clients may have a medication that is time sensitive. Those clients will be given priority over others. In the event that I am unable to see you on a scheduled appointment due to sudden scheduling conflicts or illness, how would you prefer to reschedule your appointment? (Please circle)

Phone Call Text Email (please write below which contact number/address you prefer)

(Initial)_____ _____

Payments

You are responsible for payment of your scheduled time. I understand that emergencies occur and I will take those situations into consideration. I accept **Mastercard, Visa, CHRD gift cards, checks,** and **cash** for your convenience. Please note that there is a **$75 fee** on any returned check.

(Initial) _____

Cancellations

Appointments scheduled for up to an hour require a 24 hour advanced cancellation notice. Appointments lasting any longer require a 72 hours advanced cancellation notice. Any cancellation made less than the time requested or "no- shows" will be charged accordingly. Payment will be due by or upon your next visit. All future appointments will require a 50% deposit and are at the discretion of Chenery. Please notify me of any cancellations by phone (503-320-5380)

Late Cancellation Fee, Electrolysis Treatment = 100% of visit cost

(Initial) _____

Wellbeing & Respect

I maintain a high standard of cleanliness for the sake of our clients and staff. If you are showing signs of being ill I may ask that you notify us and we will reschedule you for a better time. I will decline your treatment if you show signs of being sick.The health of our clients and staff is critical to a safe and productive environment that I take very seriously.Our lobby is shared with many people so we ask that you refrain from cellphone use and disruptive behavior. We welcome friendly conversation as we respect the other clients in the waiting room and treatment rooms.

(Initial) _____

I sincerely hope that you will help me make the best of our time together by adhering to our policies.and encourage you to ask questions. Please ask any questions before signing.I acknowledge that I read, understand and accept the terms above in regards to treatment procedure.Client

Client Name:_____ **Date:**_____

Client Signature:_____

Chenerology Electrology

Chenerology Electrolysis Informed Consent Form

The Procedure & You

The concept of using electric current for hair removal has been available since the late 1800's, and has been improving ever since. Electrolysis treatments are a form of electrical epilation where a single-use, disposable wire filament is inserted into the hair follicle (a natural opening in the skin) and a minimal amount of current is delivered to the root of follicle to destroy it through a variety of modalities. All modalities will affect only the active hair follicle, making this a direct route to target unwanted hair.

It is imperative that we treat hairs in the correct cycle. The desired stage is when hairs are first growing.

Galvanic Electrolysis - Galvanic electrolysis is the oldest type for of this hair removal. The direct current used is extremely effective but very slow. It creates a chemical change in the follicle to disable the root.

Thermolysis – Thermolysis uses shortwave radio frequency or AC current. Thermolysis causes the water molecules by your hair to rapidly vibrate, which produces heat. When enough heat is created, thermolysis damages the cells that cause hair growth.

Blend Electrolysis – This method combines both galvanic and thermolysis into one process. The heat from thermolysis heats up the chemical created in galvanic and speeds up the process. This is a wonderful modality that is used only by highly trained electrologists.

Before Your Treatment

§☐ Refrain from bleaching, plucking, threading, electrolysis or waxing of hairs in desired treatment area for six weeks when at all possible. It's fine to cut, shave or trim the area.

§☐ If you have a history of herpes or cold sores, you may need antiviral medication. This medication should be started one day before laser treatment and continued for one week after treatment.

§☐ The area for treatment needs to have the hair showing to a short stubble or longer.

§☐ Arrive with the treatment area clean and free of makeup (if treating the face) The genital area needs to be appropriately cleaned **(Initial)** _____

§☐ Cleanse the area with a mild antiseptic such as 70% isopropyl alcohol, witch hazel, or sea breeze and avoid using soaps or abrasive material when you are 24 hours post-treatment.

§☐ Do not pick, rub or scratch the area. Do not use any irritating substances on the treated area until the skin returns to normal.

§☐ If the treated area will be exposed to sun, apply SPF 50 or greater after the skin returns to normal.

§☐ If your face was treated, you may resume using clean makeup when the skin looks and feels back to normal.

§☐ As part of your electrolysis appointment we do a very thorough aftercare procedure.

§☐ You may follow your usually cleaning or makeup routine. If there are any issues, please call me.

Chenerology Electrology

Chenerology Electrolysis Informed Consent Form

What To Expect

Our hair is constantly changing from a number of factors that make us who we are, it's in our DNA. It is this diversity that makes proper hair removal through electrolysis a process. As our body reacts to different situations such as hormones, medications, weight and even our genes, our hair growth pattern changes and may activate dormant hair follicles.

The complex nature of hair growth controls the number of sessions required to reach your personal preference of hair removal. Generally, electrolysis results are noticeable within 3 months and can take 12 -18 months for completion. We offer sessions from 5 minutes to several hours and will recommend a schedule fit for you so we can treat the follicle right when it emerges and at its optimal time for reaction. Cary Hair Removal Center's goal is to see this process though to ensure complete satisfaction.

Each individual has a different tolerance level, and that is taken into consideration by the electrologist. Modern electrolysis methods can be described as causing a tingling or warming sensation, but is considered to be comfortably tolerable. Topical desensitizing creams can be applied to help ease the sensation. After your treatment, it is common to experience redness or swelling, both of which are usually short lived. These are both natural reactions from the stimulus applied the follicle and can be eased with the use of an ice pack and witch hazel. In order to prevent any additional reaction, it is critical that you inform us of any medical conditions, medications, supplements, lotions and oils.

Acknowledgement

_____ I understand that the treatment is not guaranteed due to risks of complications, both known and unknown to the technician and myself.

_____ I understand that the results are reliant on the accuracy of information I have provided Chenerology Electrology regarding my medical history and my adherence to proper before and after care.

_____ I understand that possible side effects may include, but are not limited to:

o Inflammation of the hair follicle o Edema (swelling) o Purpura (bruising) o Redness directly after treatment

_____ I understand that the frequency and longevity of treatments is determined solely by my body's natural hair growth and therefore not predetermined.

I acknowledge that I read, understand and accept the terms above in regards to electrolysis hair removal treatment.

Client signature:_____

Client Printed Name:_____

CHENEROLOGY HIPPA FORM

ONLY FOR CLIENTS WITH OHP BILLING

I,_____, hereby authorize the use or disclosure of my protected health information as described below:

1. **Authorized Persons To Use and Disclose Protected Health Information.** Chenerology authorized to disclose the following protected health information to my Electrologist, Chenery Whittier at Chenerology & Company of Fairview, Oregon 97024.
2. **Description of Information To Be Disclosed. The health information that may be disclose is:**
   Medical records
   Communicable diseases (including HIV and AIDS)
   Mental health records
   All treatment records
   Other: OHP Insurance's

Only health information from December 01,2024 to December 01, 2050 may be shared.

III. **Purpose of the Use or Disclosure.** The purpose of this use or disclosure is For Billing OHP Chenery Whittier @ Chenerology.

IV. **Validity of Authorization Form.** This Authorization is valid beginning on May 01, 2025 and expires When the client no longer needs Chenerology to bill their OHP Insurance or other insurance.

V. **Acknowledgment.** I understand that the information used or disclosed under this Authorize Form may bo subject to re-disclosure by the person(s) or facility receiving it and would then no longer he protected by federal privacy regulations.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at anytime. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

SIGN:_____ **DATE:**_____