Name: _____ **Age:** _____ **Date of Birth:** ___/___/___ **Gender:** M F

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

*Please check off your preferred contact number:
Home ☐ _____ **Cell** ☐ _____ **Work** ☐ _____

E-mail: _____ **How did you hear about Blu Cocoon :** _____

In case of emergency, whom should we contact? _____ **Phone:** _____

Past Medical History

Asthma	☐ YES	☐ NO	Hepatitis A/B/C	☐ YES	☐ NO
Bleeding Disorders	☐ YES	☐ NO	High Cholesterol	☐ YES	☐ NO
Blood Clots/DTV	☐ YES	☐ NO	Liver or Kidney Problems	☐ YES	☐ NO
Polycystic Ovary Disease	☐ YES	☐ NO	Mental Illness/ Psychiatric History	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Other Intestinal Disease	☐ YES	☐ NO
Cold Sores	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Coronary Artery Disease	☐ YES	☐ NO	Stomach Ulcers	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Thyroid Disease	☐ YES	☐ NO
Lupus Erythematosus	☐ YES	☐ NO	Reactions to Anesthesia	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO	Other:_____	☐ YES	☐ NO

List any active medical problems you have: _____

Are you currently being treated for any medical condition? YES NO
Explain_____

FEMALES: **Are you pregnant or breastfeeding?** YES NO
Are you planning pregnancy during the course of your treatment? YES NO

List any medications you currently take, including supplements:

_____

List any medication allergies OR sensitivities you have/reaction:

_____

Are you allergic to any metals? YES NO **Are you allergic to latex?** YES NO **Do you use any tobacco products?** YES NO

List any operations you have had/dates:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Dermatologic History

Photosensitivity	☐ YES	☐ NO	Keloid or hypertrophic scar	☐ YES	☐ NO
Chronic skin conditions	☐ YES	☐ NO	Herpes simplex or cold sores	☐ YES	☐ NO
Pigmentation disorder	☐ YES	☐ NO	Skin cancer	☐ YES	☐ NO
Psoriasis	☐ YES	☐ NO	Accutane use for acne	☐ YES	☐ NO
Rosacea	☐ YES	☐ NO	Tetracycline use for acne	☐ YES	☐ NO
Vitiligo	☐ YES	☐ NO	Dermal Filler	☐ YES	☐ NO
Tattoos	☐ YES	☐ NO	Permanent makeup	☐ YES	☐ NO
Hemorrhoids	☐ YES	☐ NO	Botox®/Dysport injection	☐ YES	☐ NO
Kaposi's sarcoma	☐ YES	☐ NO	Laser skin resurfacing	☐ YES	☐ NO
Port-wine stain	☐ YES	☐ NO	Chemical peel	☐ YES	☐ NO
Hirsutism	☐ YES	☐ NO	Recent sunburn or tan	☐ YES	☐ NO
Acne	☐ YES	☐ NO	Waxing/plucking/electrolysis	☐ YES	☐ NO
Burns/Skin grafts	☐ YES	☐ NO	Other:_____	☐ YES	☐ NO

Skin Tone: □ Pale □Light Pink □Medium Pink □Light Olive □Dark Olive □Light Brown □Dark Brown □Black

What is your ethnic background? _____

When exposed to the sun, do you usually:

□ Always burn, never tan □ Burn easily, tan poorly □ Tan after initial burn
□ Burn minimally, tan easily □ Rarely burn, tan darkly easily □ Never burn, always tan darkly

Do you use sunscreen regularly? YES NO **Do you use artificial or "sunless" tanning products?** YES NO
Do you use Tanning Beds? YES NO **Does your skin remain discolored after healing from a cut?** YES NO

List any special skin care products you use: _____

What concerns do you have about your skin: _____

Please check the services you are interested in:

☐ Vibradermabrasion	☐ Pigmentation Removal	☐ Sun Damage Repair
☐ Vein Removal	☐ Wrinkle Reduction	☐ Medical Grade Skin Care Products
☐ Body Contouring	☐ Cellulite Reduction	☐ Mineral Make Up
☐ Filler Injections	☐ Botox®/Dysport	☐ Facials
☐ Laser Hair Reduction	☐ Skin Tightening	☐ Obagi Products
☐ Chemical Peels	☐ Acne Treatment	☐ B12 Injections

I attest that my answers are true and correct. I will inform Blu Cocoon MedSpa of any changes in my medical condition, including new medications and supplements, during the course of my treatment

Patient Signature: _____ **Date:** _____

Blu Cocoon Staff: _____ Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice applies to all records of your care generated and maintained by this medical spa.
We are required by law to: 1) make sure that medical information that identifies you is kept private; 2) make available to you this Notice of our legal and privacy practices with respect to medical information about you; and 3) follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may disclose medical information about you to doctors, nurses, or other personnel involved in taking care of you. We may also disclose medical information to people outside the medical group, such as family members, specialists or others who are involved in providing services that are part of your care. We may use or disclose medical information about you for operations. These may include use of information to evaluate the performance of our staff, effectiveness of programs, and ways to improve care and services we offer. These uses and disclosures are necessary to ensure that all of our patients receive quality care. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or care. We may use or disclose medical information to tell you about or recommend possible treatment options or alternatives, and about health-related benefits, services, events and activities that may be of interest to you. We may disclose medical information about you to other healthcare providers in the event you need emergency care. We may disclose medical information about you as required by federal, state or local law. We may use or disclose medical information to a public health organization or federal organization when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. We may disclose medical information about you in special situations such as for workers' compensation programs, as required by military command authorities or the Department of Veterans Affairs, in response to a court or administrative order, or for public health activities. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may later revoke this permission in writing at any time.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the right to review and receive a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records. You must submit a written request to review and copy your medical information. We may charge a fee for the costs of supplying a copy of the records. You have the right to ask us to amend medical information that you feel is incorrect or incomplete. Your request for an amendment must be submitted in writing and must provide a reason that supports your request. We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information: 1) was not created by us; 2) is not part of the medical information kept by or for us; 3) is not part of the information which you are permitted to inspect and copy; or 4) is accurate and complete You have the right to request an "accounting of disclosures." This is a list of disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and include: 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosures to you. You must submit a written request. The request must state a time period that may not be longer than six years and may not include dates before April 14, 2003, when current federal health privacy laws became effective. You have the right to request restrictions or limitations on the use or disclosure of medical information about you. You must submit a written request for restriction that specifies: 1) what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply. We reserve the right to refuse your restriction if it is in conflict with providing you quality healthcare or in an emergency situation. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as only at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contacted. We will accommodate reasonable requests. You have the right to possess a copy of this Privacy Notice upon request. You may receive a paper copy of this notice, or you can also obtain a copy of this Notice at our offices. You have the right to file a complaint if you believe your rights to privacy have been violated. All complaints must be submitted in writing. All complaints will be investigated. *No personal issue will be raised for filing a complaint.*

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We will post a copy of the current notice at our clinical site.

Acknowledgment of Receipt

Notice of Privacy Practices provides information about how we, Blu Cocoon MedSpa, may use and disclose your protected health information.

I, _____ acknowledge that I have read the Notice of Privacy Practices.

_____ _____
Signature of Patient **or** Patient's Representative Date

_____ _____
Print Name Relationship to Patient

FINANCIAL POLICIES

Our focus is on anti-aging medicine and aesthetic procedures that are typically not covered by insurance carriers; therefore we do not bill insurance companies. We are a fee for service-based practice offering our clients fair and competitive rates.

PAYMENT OPTIONS

Payment for all medical spa procedures is due at the time of the treatment. For specially packaged or grouped treatments, payment for the entire package is due at the time of the first scheduled treatment. We accept cash check and most major credit cards. Payment is required at time of service.
A CREDIT CARD IS REQUIRED TO RESERVE AN APPOINTMENT.

CANCELLATION & REFUND POLICY

We require the courtesy of a 24-hour cancellation notice. A $50 cancellation charge will be incurred for cancellations that occur within 24 hours of the appointed time. If you do need to cancel your appointment, kindly give us the earliest possible notice so we may accommodate another client.

CREDIT CARD TYPE:_____ NAME ON CARD:_____

CARD NUMBER:_____-_____-_____-_____ EXP DATE:_____/_____

In the event that a package or series of treatments has begun, these services will be considered to have been rendered even though the full series may not have been completed. Should you wish to discontinue your treatment in the midst of a series, store credit for the pro-rated share of unused treatments at the discounted package price may be extended, and this may be used to purchase other treatments or products offered by Blu Cocoon Medical Spa.
THERE CAN BE NO REFUNDS FOR SERVICES ALREADY PROVIDED.

REVISIONAL TREATMENT OR TREATMENT OF COMPLICATIONS

The practice of medicine and surgery is not an exact science, and medical spa treatments are the practice of medicine. Although good results are anticipated, **there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results you may get.** Occasionally additional treatments and/or treatment for problems or complications may be required. These could result in additional charges for which you may be responsible. Your insurance, if you have it, may or may not cover the expenses related to actual complications or other medically related problems arising out of treatment at Blu Cocoon Medical Spa.

SPA REGULATIONS AND GUIDELINES

At Blu Cocoon we offer our clients an escape from the daily stresses of life. We request that the Med Spa atmosphere not be disturbed by cell phones, pagers, etc. and ask that you turn them off upon entering the facility. Additionally, we kindly ask that **children ages 15 and under not accompany you as we do not have facilities for children.**

I acknowledge that I have read and fully understand the foregoing policies and my obligations related thereto:

_____ _____

Patient Signature **Date**

*These Policies are subject to change without notice. If you have any questions or need assistance with any financial matters relating to your treatment, please contact the Medical Spa Coordinator for help.

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contact were unauthorized or were improperly, negligently, or incompetently rendered will be determined by submission to arbitration as provided by state law, and not by a lawsuit or court process except as therein constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of the arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by provider including any spouse or heirs of the patient and any children whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mothers expected child.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the provider and its partners, associates, corporation , and the employees, agents and estates of any of them, must be arbitrated including, without limitation , claims for loss of consortium, wrongful death, emotional distress or punitive damages.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days (30) and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within Thirty days (30) of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of judicial officers from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law:

Either party shall have the absolute right to arbitrate separately the issues of liability and damage's upon written request to the neutral arbitrator.

The parties consent to the intervention and joiner in this arbitration of any person or entity which would otherwise be a proper additional party in a court action and upon such interaction and any existing court action against such additional person or entity shall be stayed.

The parties agree that provisions of state law applicable to health care providers shall apply to disputes with this arbitration agreement. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication. Discovery shall be conducted pursuant to applicable state law; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions**: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by applicable laws relating to arbitration.

Article 5: **Revocation**: This Agreement may be revoked by written notice delivered to the provider. It is the intent of this Agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to emergency surgery) patient should initial below:**

Effective as of the date of first medical services _____ Initial

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Patient Name Date

_____
Patient or Patient Representative's Signature

By: _____ _____
Provider Authorized Representative's Signature Date

Plastic surgery is a visually oriented specialty. As such it is necessary that medical photographs be taken before, during and after a surgical procedure or treatment.

Additionally, patients may consent to release these medical photographs/slides, and videotapes for a stated purpose such as for use in instructional, educational, or promotional materials. These materials are very important to insure continued understanding of the treatments available to all patients. Please read carefully the information contained in both sections below, and provide your consent where applicable.

- **A SIGNATURE IN SECTION 1 IS REQUIRED TO RECEIVE YOUR CARE AT BLU COCOON MEDICAL SPA**
- **A SIGNATURE IN SECTION 2, WHILE ENCOURAGED, IS OPTIONAL**

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Dr. Howard Rosenberg, Medical Director of Blu Cocoon Medical Spa, and/or his associates or licensees to take pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes.

I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation by Dr. Howard Rosenberg, and/or the staff of Blu Cocoon Medical Spa, and I understand that they shall be made a part of my medical record.

Patient Signature: _____ **Date:** _____

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Dr. Howard Rosenberg, MD, Medical Director of Blu Cocoon Medical Spa, and or his associates or licensees to use pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes for professional medical or promotional purposes as deemed appropriate by them including but not limited to display of these images on public or commercial television, electronic digital networks, scientific medical publications, lay publications, or during lectures to medical or lay groups for the purposes of informing the medical community or the general public about plastic surgery and skin rejuvenation procedures available at Blu Cocoon Medical Spa.

Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and I hereby grant this consent as a voluntary contribution in the interest of medical education. This permission may be rescinded by me at any time to prohibit future use by direct written communication with Dr. Howard Rosenberg, or Blu Cocoon Medical Spa.

Patient Signature: _____ **Date:** _____