Patient Information

Today's Date:_____ Date of Birth:_____

Last Name:_____First Name:_____ M.I._____

Cell Phone:_____ Home Phone: _____

Email Address:_____

Street Address:_____City:_____

State:_____Zip Code:_____

Employer:_____Occupation_____

Referred by:_____

Can we call/text for appointment confirmation: Y N

Can we leave a voicemail on the number you provided: Y N

Can we email you with information about our practice: Y N

Emergency Contact

Name:_____ Relationship:_____

Phone:_____

Medical Information

Past Cosmetic Procedures (please include product names if known) :_____

_____

History of any adverse reactions to cosmetic procedures or products? Y N

If yes, please specify product and type of reaction:_____

_____

Medical History:_____

_____

Allergies:_____

_____

Current Medications:_____

_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

- Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately.
- Patient files may be stored in open file racks and will not openly contain any information which identifies a patient's condition or information which is not already a matter of public record. Such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff .
- It is the policy of this office to contact patients regarding their appointments, past or current care, office policies , information and updates through telephone, text-message, e-mail, or by any means convenient for the practice unless specifically requested by you otherwise.
- The practice utilizes vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
- You understand and agree to inspections of the office and review of documents which may include PHI by government agencies in normal performance of their duties.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office staff.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
- We agree to NOT share any of your confidential chart information or patient photos unless you specifically give us permission to through a separate agreement form.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

By providing my signature below I, _____ consent and acknowledge my agreement to the terms above regarding HIPAA and any subsequent changes in office policy.

Signature:_____Date:_____

Social Media Consent Form

Please be aware that we will need to take before and after photos of your procedure/treatment for medical documentation. We would like your permission to use these photos for informational and advertising purposes. Upon your approval, this may include social media platforms such as Instagram, Facebook or Twitter, as well as our office website, clinical staff's personal/work Instagram accounts, and before/after photo books.

*Please read ALL options before signing consent

- ▢ **Yes**, RaymondMD Aesthetics may use my photos.
- ▢ **No**, do not use my photos for any purpose other than chart documentation.

If you allow us to use your photos, please specify the following:

- ▢ **Use photos of the treated area only**
  (only lips, lower face, full face with eyes blocked out)
- ▢ You may use photos of my **entire face.**

Please check which resources we may use your photos on:

- ▢ Instagram/Facebook/Twitter
- ▢ RaymondMD Aesthetics website
- ▢ Before and after photo albums
- ▢ Clinical Staff personal/work IG accounts

Name (Print) :_____

Signature:_____**Date:**_____