PHOENIX
TATTOO REMOVAL
&
SKIN REVITALIZATION

NEW PATIENT PAPERWORK

Patient Name: ____ DOB: __________________

Street: ____ APT#:______________________

City:_______________________________ State: _______________ Zip Code: __________________

Home:_________________________________ Cell: _______________________________________

Email: _________________________________ How did you hear about us: ________________________

Emergency Contact:

Full Name: ____ Relation: __________________________

Home Phone: ______________________________ Cell Phone: ___________________________________

Area of Concern: ____

Medications: you are currently taking: ____

Topical medications prescription/non prescription ____

Allergies: ____

Do you use Sun block regularly? Yes / No

Have you had any sun exposure in the last 4 to 6 weeks including: tanning beds, tanning/bronzing creams, or Spray on tans? Yes / No If yes, please specify____

Do you have any tattoos or permanent make up? ____

Do you have any tattoos containing gunpowder? ____

Have you ever had gold therapy? ____

Tell us about your skin goals: ____

Patient Name: ____ DOB: _______________

Past and Present Medical History:

If all are **negative** then check here: _________

Please Circle Your Answers:

Anxiety	Lupus	Tuberculosis
Asthma	Fibromyalgia	Liver Disease
Gout	Osteoporosis	Kidney Disease
Seizures	High Cholesterol	Cancer: ___________________
High Blood Pressure	Reflux Disease	Other: ___________________

Are you pregnant? Yes No

Do you or have you had skin cancer? Yes No

If so, where did you have skin cancer? Area(s) ____

Is it in the area you want treatment? Yes No

When was your last dermatologist check? Date: ___________________

Do you have a history of Keloid scarring or any other textual skin changes after procedures? Yes No

Have you recently been on Accutane in the past 6 months? Last date used: _______________ Yes No

Do you use exfoliating products? (i.e. Retin-A, retinol, or aggressive scrubs) Yes No

If so, when were they last used? ____________________________________

Do you have a cold, flu, or any other sickness? Yes No

Do you take corticosteroids? Yes No

Do you have blood disorders? Yes No

Do you use blood anticoagulants? Yes No

Do you have Herpes in or around the treatment area? Yes No

If so, you must take an antiviral for 2 days prior to treatment, day of treatment, and 2 days post treatment.

Do you have Diabetes or any other medical condition that will impair the healing process? Yes No

Do you experience Vitiligo? Yes No

Do you have Eczema or Psoriasis? Yes No

Do you experience Allergic Dermatitis? Yes No

Is your immune system compromised in any way? (i.e. HIV, Steroids or age) Yes No

Do you have any collagen diseases such as Ehlers-Danlos or Scleroderma? Yes No

Do you have any social engagements in the next 2 days? Yes No

Do you currently have any dermal fillers in the treatment area? Yes No

Do you have a history of hypo/hyperpigmentation? Yes No

Are you under a Doctor's care? If so for what reason___________________________________ Yes No

Fitzpatrick Skin Type Form

Patient Name: ________________________________ DOB: ______________

Score	0	1	2	3	4
Color of Eyes	Light blue, gray, green	Blue gray or green	Blue	Dark Brown	Brownish black
Natural hair color	Sandy red	Blond	Chestnut/dark blond	Dark brown	Black
Skin color (non-exposed areas)	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
Freckles in unexposed areas?	Many	Several	Few	Incidental	None
Skin reaction if stays in the sun too long?	Painful, blistering, redness, peeling	Burns followed by peeling	Burns sometimes followed by peeling	Rare Burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light tan color	Reasonable tan	Tan very easily	Turn dark brown
Do you turn brown within several hours after sun exposure?	Hardly or not at all	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very Resistant	Never had a problem
When did you last expose your body to sun or sun beds?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Skin Type	Dry	Oily	Combination	Problem
Characteristics	Whiteheads/Comedones	Dilated Capillaries	Mature	Blemishes
Condition/Elasticity	Wrinkles	Normal/Fair	Scars	Discoloration

Clinic Staff to complete this portion:

Total Score of all questions ____________

Skin Type Score	Fitzpatrick Type
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

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SKIN REVITALIZATION

PHOTOGRAPHY PERMIT

I hereby authorize the appropriate personnel of Phoenix Tattoo Removal to take digital pictures of area being treated by the PicoSure laser and Alma Harmony Laser.

I hereby state that it has been fully explained to me that said pictures are taken for the purpose of medical record documentation and for the showing to the duly licensed physicians, providers, and authorized laser technicians.

I further state that at the time of the execution of the consent, that I am fully aware of the pictures to be taken and the uses, as above described, to which they are to be put, and that all questions with respect to the taking of the pictures and the use thereof have been fully explained to me and to my complete satisfaction by personnel of Phoenix Tattoo Removal

______________________________ _______________
Signature Date

____
Printed Name

PHOENIX

TATTOO REMOVAL

SKIN REVITALIZATION

CANCELLATION AND NO SHOW POLICY
****IMPORTANT INFORMATION Please read carefully****

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice from your appointment time. This will enable for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other patients.
Office appointments which are cancelled with less than 24 hours of your appointment time will be subject to a $50.00 cancellation fee.

Example: If you have a 10:00 am appointment, you must contact the office by 10:00 am the day before. Patients who do not show up for their appointment without a call to cancel an office appointment are considered as NO SHOW or call on the same day to cancel.

I have read and understand Please initial ______

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment and/or agree to charge your credit card.

I have read and understand Please initial ______

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

I have read and understand Please initial ______

You will receive a text message and/or e-mail reminder, you may confirm, PLEASE DO NOT CANCEL OR RESCHEDULE through the reminder instead call the office immediately to cancel or reschedule.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to us.
We ask that you add Phoenix Tattoo Removal and skin Revitalization to your contacts 602-802-8800
Please sign that you have read, understand and agree to this Cancellation and No show Policy.

______________________________________ ______________________________

Patient Name (Please Print) Date of Birth

______________________________________ ______________________________

Signature of Patient or Patient Representative Date

** OFFICE COPY

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** PATIENT COPY **

YOUR COPY

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NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operation. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have the right to review the Notice of Privacy Practices prior to signing this consent. Phoenix Tattoo Removal reserves the right to revise this Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Phoenix Tattoo Removal Privacy Officer at 4840 E Indian School Rd Ste 102, Phoenix, AZ 85018, 9305 W Thomas Rd, #350, Phoenix, AZ 85037, 5700 W Olive Ave. #101, Glendale, AZ 85302 and 4515 S. McClintock Dr. #101, Tempe, AZ 85282

With my consent , Phoenix Tattoo Removal and Skin Revitalization, Judith Goldman CMLT, LSO may call my home or to other designated location and leave a message on a voice mail or in person in reference to any items that assist the practice in carry out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Phoenix Tattoo Removal and Skin Revitalization, Judith Goldman CMLT, LSO may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

By signing this form, I am consenting, Phoenix Tattoo Removal and Skin Revitalization, Judith Goldman CMLT, LSO to use and disclosure of my Personal Health Information to carry out treatment, payment and healthcare operations. I have also read the Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Phoenix Tattoo Removal and Skin Revitalization may decline to provide treatment to me.

I hereby acknowledge that I have been presented with a copy of Phoenix Tattoo Removal and Skin Revitalization l Notice of Privacy Practice.

______________________________ ____________________________ __________________

Patient's Name (PRINT) **SIGNATURE** **Date**

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3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

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