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:_______________________________________ Phone number:_____________________

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____

If you are here for Tattoo Removal please answer the following:

Does your tattoo or permanent make-up contain white ink? Yes / No

If you answered yes, please know that white ink will oxidize (turning dark grey or blackish in color) when treated with laser tattoo removal.

If you are not sure if your tattoo or permanent make-up contains white ink, do you still want to take the risk of the area oxidizing? Yes / No **Please Initial** _________

Do you have any tattoos containing gunpowder? Yes / No

Have you ever had gold therapy? Yes / No

If you are here for Skin Revitalization tell us about your skin goals:________________________________

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Patient Name: ____ DOB: ________________

Past and Present Medical History:
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: ___________________

When was your last dermatologist check? Date: ___________________

YES / NO (PLEASE CHOOSE FOR EACH)

Yes / No Are you pregnant?
Yes / No Do you or have you had skin cancer? If so, where did you have skin cancer?
Area(s)_________________________ Is it in the area you want treatment?
Yes / No 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? If so, last date used: ___________
If you are getting laser or micro needling treatments, you must wait 6 months.
Yes / No Do you use exfoliating products? (i.e. Retin-A, retinol, or aggressive scrubs)
If so, when were they last used? ________________ If you are getting laser or micro needling treatments, you must wait at least 3 days.
Yes / No Do you have Herpes in or around the treatment area? *If so, you must take an antiviral for 2 days prior to treatment, day of treatment, and 2 days post treatment.*
Yes / No Do you have Diabetes or any other medical condition that will impair the healing process?
Yes / No 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 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____________________

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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 only.

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

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 a 24 hour notice from your appointment time. This will allow for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than a 24 hour 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.

- 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.

- 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.

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. WHY?

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 (Print)____________________________________Date of Birth________________

Signature____Date______________________

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 the 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 disclosures 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, #405, Phoenix, AZ 85037, 5700 W Olive Ave #101, Glendale AZ 85302, 4515 S McClintock Dr #101, Tempe, AZ 85282, and 10204 W Happy Valley Pkwy Ste 165, Peoria, AZ 85383.
With my consent, Phoenix Tattoo Removal and Skin Revitalization, Angela Rasmussen CMLT, LSO may call my home or to other designated location and leave a message on voicemail 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, Angela Rasmussen 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, Angela Rasmussen CMLT, LSO to use and disclosure of 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 sigh 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 Notice of Privacy Practice.

______________________________	______________________________	____________
Patient’s Name (PRINT)	SIGNATURE	DATE