DR. KEVIN JOHNSON'S Advanced Aesthetics

522 W Riverside, Suite 202
Spokane, WA 99201
(509) 209-2171

608 Northwest Blvd. Suite 301
Coeur d' Alene. ID 83814
(208) 676-8346

Patient Name _____ Sex: M __ F__ DOB_____ Today's date _____

Address _____ City _____ State _____ Zip _____

Home (_____)_____Cell (_____)_____Work (_____)_____Primary contact number? (H) (C) (W)

Marital Status: (S) (M) (W) (D) Occupation _____Employer _____

Emergency Contact _____Relation_____ Phone (_____) _____

Email Address: _____

(Y) __ (N)___ I would like to receive future monthly emails for promotional events, discounts, and specials from Advanced Aesthetics. Please Note: Your email address is used strictly for our communication with you and will not be given out.

How did you hear about us? Website/Internet___ Facebook___ Email___ TV Commercial___ Newspaper___ Billboard___ Radio___ Friend/Relative (name)_____ Other (please specify)_____

HEALTH INFORMATION

Which concerns apply to you? Please circle all that apply.

Black or Whiteheads	Brown spots (hyperpigmentation)	Cellulite	Clogged pores
Dry patches	Enlarged pores	Excessive oiliness	Scarring
Skin laxity	Spider veins	Stretch marks	Upper lip lines
Unwanted body fat	Unwanted hair	Uneven skin tone	Varicose Veins
Tattoo	Visible exposed blood vessels	White spots (hypopigmentation)	Wrinkles

Other: _____

Are you pregnant or trying to become pregnant?_____ Do you use oral contraceptives? _____

Do you have any neuromuscular or autoimmune diseases? (Y) ___ (N) ___ List: _____

_____

Do you have any allergies to medications? (Y) ___ (N)____ If yes, please specify and state type of reactions:

_____

_____

Do you take oral anti-coagulant (blood thinning) medication? (Y) __ (N) __ Specify: _____

Do you take Aspirin, Advil, Motrin, Ibuprofen, or anti-inflammatory meds more than once a week? (Y) __ (N) __ If yes, please explain: _____

List all medications you are taking (prescription and over the counter): _____

_____

_____

Do you have allergies to latex? (Y) __ (N) __

Do you have a fear of needles? (Y) __ (N) __

Please list all surgeries or hospitalizations with dates:

_____

_____

_____

Have you had any cosmetic procedures in the past? Please list with dates: _____

_____

_____

Are you allergic to any cosmetic ingredients or foods? (Y) ___ (N) ___ If yes, please list:

_____

_____

Do you smoke? (Y)___ (N) ___ If yes, how many per day _____ How many years _____

Do you drink alcohol? (Y) __ (N) __ If yes, how much _____ How often _____

Have you ever had any of the following (please circle):

Asthma	Arthritis	Anemia	Autoimmune disorder	Blood disorder
Chest pain	Clotting disorder	Diabetes	Depression	Easy bruisability
Excessive scarring	Excessive bleeding	Gold Therapy	Heart attack	Heart valve disease
Heart failure	Heart valve replacement	Hepatitis	High blood pressure	HIV
Hormonal problems	Irregular heart beat	Intestinal problems	Impaired skin sensation	Impaired circulation
Keloids (scars)	Kidney disease	Liver disease	Lung disease	Multiple Sclerosis
Muscular dystrophy	MVP	Migraines	Open Infected wound	Pregnancy
Paroxysmal cold hemoglobinuria		Raynaud's disease	Rheumatic fever	Seizures
Shortness of breath	Skin cancer	Stomach problems	Stroke	Thyroid disorder

Cancer: (Please list type) _____

Please complete this section if you are interested in:
SMARTLIPO / COOLSCULPTING/ CELLULAZE

Age: _____ Current Weight: _____lbs Height: _____ Is your general health good? (Y)__ (N)__

Name of family physician _____ Date of last physical _____

What attracted you most to learning about Smartlipo / Coolsculpting or Cellulaze? _____

_____

What problem area(s) are you considering having treated? (Please circle area or areas)

Abdomen	Inner Thighs	Arms	Neck
Flanks (Muffin Top)	Outer Thighs	Upper Back (Bra Area)	Male Chest
Other_____			

PATIENT'S SIGNATURE:

To the best of my knowledge, the information provided above is true and accurate.

Patient Signature _____Date_____

Provider Signature_____Date_____

Since 2008, physicians from all over attend Smartlipo courses at Advanced Aesthetics from Dr. Kevin Johnson, the most sought after cosmetic physician. Check here if you would like more information about becoming a training model: _____

Please complete this section if you are interested in:
INJECTABLES / LASERS / SKIN CARE

What is your skin type: (please circle) Dry Oily Normal Combination

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation:
Please list: _____

_____

_____

Have you ever had any of the following Injectables or implants: (please circle)

Dysport	Restylane	Voluma	Sculptra	Perlane	Lipo Dissolve
Botox	Juvederm	Radiesss	Silicone	Collagen	Hylaform

Other: _____

If so, when was it done _____ What area(s) _____

Please check the products you currently use and list the BRAND NAMES (if possible) of Cosmetic Products:

Cleanser _____ Soap _____

Moisturizer _____ Night Cream _____

Toner _____ Eye Cream _____

Mask _____ Glycolic Wash/Cleanser _____

Astringent _____ Scrub _____

Salicylic Wash/Cleanser_____ Sunscreen _____

Vitamin A Cream _____ Vitamin C Creams _____

Alpha or Beta Hydroxy Cream _____

Do you have any of the following chronic skin disorders? (please circle)

Psoriasis Dermatitis Eczema Keloid Scarring Cold Sores Sun Blisters Fever Blisters Herpes Simplex/Blisters

Have you ever undergone any of the following treatments? (please circle)

Microdermabrasion Acid Peel Cosmetic Surgery Accutane

Are you currently removing hair by any of the following methods? (please circle)

Laser Hair Removal Waxing Tweezing Nair type products Electrolysis

If so, when was it done? _____ What area(s)? _____

What type of laser equipment was used? _____

PATIENT'S SIGNATURE:

To the best of my knowledge, the information provided above is true and accurate.

Patient Signature _____ Date_____

Provider Signature_____ Date_____

HIPPA - PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, **Advanced Aesthetics** may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Advanced Aesthetics**' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Advanced Aesthetics** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Advanced Aesthetics**' Privacy Officer at 608 Northwest Boulevard, Suite 301; Coeur d'Alene, ID 83814.

With my consent, **Advanced Aesthetics** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO. I also consent in the mailings to my mailing address to receive items such as appointment reminder cards and/or patient statements or any forms that are requested by patient and/or practice.

With my consent, **Advanced Aesthetics** may e-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. I have the right to request that **Advanced Aesthetics** restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Advanced Aesthetics**' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Advanced Aesthetics** may decline to provide treatment to me.

_____ _____ _____

Patient's Signature Please Print Your Name Date

_____ _____

Provider's signature Date

ADVANCED AESTHETICS' NO SHOW AND CANCELLATION POLICY

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointments with Advanced Aesthetics are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs and to contain our fees, we maintain a **No Show/Cancellation Policy** for all our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance. Cancellations must be made between 8 a.m. and 5 p.m. on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the telephone by speaking directly to one of our scheduling professionals. Patients will not be charged for an office visit if cancellation is made 24 business hours before their appointment.

In the event an appointment is missed or cancelled with less than 24 hours' notice or no notice, a $75 charge will be billed. If a second no-show or same day cancellation occurs, we reserve the right to terminate the patient-doctor relationship. This policy is in effect for all appointments at our office, including clinical and cosmetic appointments. Again, all no-shows or same-day cancellations will be charged $75 if not cancelled with a 24 business hour notification.

Finally, we advise you to review this agreement with the counsel of your choosing and by signing this agreement you acknowledge that you have had an opportunity to review this agreement with counsel of your choice if you desire to do so. This agreement shall be valid and enforceable for five years from Advanced Aesthetics last date of service to you. Advanced Aesthetics reserves the right to modify any policies without notice.

My signature below indicates that I have read and understand these policies.

_____ _____

Patient or Responsible Party Signature **Today's Date**