Capital Medical Group --CAPITAL AESTHETICS

Personal Profile and Health History

Name:_____Home Phone:_____

Address:_____Work Phone:_____

City/State/Zip: _____

Date of Birth: _____Age:_____Gender: M____F_____

Occupation: _____ Email address:_____

How did you hear about us?_____

What cosmetic/aesthetic procedures are you interested in?

_____

_____

Please share any questions, concerns or comments:_____

Females: Are you pregnant? ❑ Yes ❑ No Are you breastfeeding? ❑ Yes ❑ No
Are you planning pregnancy during the course of your treatment? ❑ Yes ❑ No

Your genetic background affects your skin and its response to the laser. Please specify your ethnic origin:
❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Mediterranean
❑ Middle Eastern ❑Native American ❑ Other _____

Please complete the following items of medical history. Please, always inform us of any change in your medical history and/or medications. Please list **all** medications including prescription and over the counter drugs, vitamins, herbs, supplements.

_____

_____

Are you allergic to any medications? ❑ Yes ❑ No Please list medications and reactions._____

☐Acne	☐ High Blood Pressure	☐ Permanent Makeup
☐Bleeding Disorders	☐ Hirsutism	☐ Precocious Puberty
☐Burns/Skin Grafts	☐ Hormone Replacement Rx	☐ Psoriasis
☐Cold Sores/Fever Blisters	☐ Implants	☐ Seizures
☐Diabetes	☐ Kaposi's Sarcoma	☐ Shingles
☐Endocrine Disorders	☐ Keloid Scars	☐ Skin Cancer
☐Excessive Bleeding	☐ Liver Disease	☐ Tattoos
☐Gold Therapy	☐ Lupus Erythematosus	☐ Thyroid Disease
☐Heart Disease	☐ Mental Disease	☐ Vitiligo
☐Herpes	☐ Neuromuscular Disease	☐ Other _____

Personal Profile and Health History

☐ Have you had surgery in the area to be treated? If "Yes", please explain

_____

_____

If the answer to any of the following questions is yes, please provide details in the space provided.

Are you currently being treated for any medical conditions?	Yes	No
Explain:_____		
Do you smoke? If so # per day?_____ _____	Yes	No
Do you drink alcohol? Amount per day? _____	Yes	No
Have you used Accutane in the last 6 months? How recently? _____	Yes	No
Do you have any active skin diseases or infection in the area to be treated?	Yes	No
Do you have any skin allergies?	Yes	No
Are you allergic to latex, lidocaine, or any lotions? Please circle any that apply	Yes	No
Are you currently using glycolic acid or Retin A? Please circle any that apply.	Yes	No
Have you had a chemical peel or facial within the last week?	Yes	No
What products are you currently using on your skin?		
Describe:		
Have you had any permanent cosmetic tattooing to the area to be treated?	Yes	No
Do you have any metal or other implants? Where? _____	Yes	No
Have you had any previous laser treatment or other skin treatment to the area		
to be treated? Describe: _____	Yes	No
Are there any moles with hair in the area to be treated?	Yes	No
Are you currently using or have used within the last six weeks a tanning bed or		
tanning cream? If yes, date of last use _____	Yes	No
Have you been exposed to the sun within the last four to six weeks?	Yes	No
If yes, approximate date of last exposure _____		

Name of your family doctor: _____ Phone No. _____

I confirm that the answers to the questionnaire are true and correct. I also confirm that the consultant has clarified any questions I did not understand.

Signature of Client: _____Date: _____

Signature of Dr./ARNP/PA _____ Date:_____

Capital Medical Group --- Capital Aesthetics
1001 Leawood Drive Suite A ◊ Frankfort, KY 40601 ◊ ph: 502.875.0872 fax: 502875.2387

FINANCIAL POLICY

Payment for Aesthetic Services is required at the time of service. These services are considered cosmetic in nature and therefore are not billable to health insurance plans.

Cancellations must be made 24 hours in advance of your appointment time. No shows or cancellations with less than 24 hours notice may result in a $25 charge.

Please expect to pay in full for the service on the day it is performed.

We accept

CASH

CHECKS

Most Major Credit Cards: Visa, Master Card, American Express, Discover

CareCredit: no interest and extended payment plans subject to credit approval.

I acknowledge that I have read the financial policy above and understand that I am responsible for payment for my services at the time of service.

_____ Date:_____

Capital Medical Group

Capital Aesthetics

Consent Form for Facial Skin Rejuvenation

1. I_____, consent to and authorize CAPITAL AESTHETICS to perform treatments on me. Light can be used effectively to destroy targets located in the skin with minimum damage to the surrounding tissues. Light is used to lighten, fade, or remove photo-damaged skin in a non-ablative manner, a procedure known as photo rejuvenation. Visible signs of photo damage include wrinkling, enlarged pores, course skin texture, and pigment alterations.

2. I am aware that erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours but can last up to seven days or longer. Irritation, itching, and/or a mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment.

3. Pigment changes such as hyper pigmentation and hypo pigmentation of the skin in the treated areas can occasionally occur. Mostly it is transient, but can last up to six months, but in rare cases, it can be permanent. Most cases of hypo- or hyper-pigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before or after treatment. Occasionally these pigment changes occur despite appropriate protection from the sun.

4. Even though appropriate measures are taken to reduce side effects, they cannot be eliminated in every case. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. There may be other treatment options, such as injections, other types of lasers/light sources or peels. With this in mind, I am choosing this non-invasive treatment for vascular and/or pigment lesions and other indicated skin conditions.

5. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as hyper pigmentation, hypo pigmentation, and other skin textural changes.

6. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

7. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

8. The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement.

I release, medical staff, and specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age.

Client Signature: _____ **Date:** _____

Skin Type Form

Skin type is often categorized according to the Fitzpatrick skin type scale, which ranges from very fair (skin type I) to very dark (skin type VI). The three main factors that influence skin type and the treatment program:

Genetic disposition ***Reaction to sun exposure*** ***Tanning habits***

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) has a major impact on the evaluation of your skin color. Please help us determine your skin type and treat you the right way. Please take a few minutes to fill-out this questionnaire, ***circling the most appropriate response***.

Name_____

Genetic Disposition

Score	*0*	*1*	*2*	*3*	*4*
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Hazel/ Brown	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/ Dark Blond	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale Beige tint	Light Brown	Dark Brown
Do you have freckles on **unexposed** areas?	Many	Several	Few	Incidental	None

Score for Genetic Disposition ☐

Reaction to Sun Exposure

Score	*0*	*1*	*2*	*3*	*4*
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very Sensitive	Sensitive	Normal	Very resistant	Never had a problem

Score for Reaction to Sun Exposure ☐

Tanning Habits

Score	*0*	*1*	*2*	*3*	*4*
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
When in the sun, do you expose the area to be treated?	Never	Hardly ever	Sometimes	Often	Always

Score for Tanning Habits ☐

What color is the hair in the area to be treated?_____

	⬅ Genetic Disposition Score	**Skin Type Score**	**Skin Type**	**Skin Color**
	⬅Reaction to Sun Exposure Score	0-7	I	Very fair, "transparent"
	⬅Tanning Habits Score	8-16	II	Fair
	⬅Total Score	17-25	III	Fair to light olive
	⬅Skin Type	26-30	IV	Olive to brown
		Over 30	V-VI	Dark Brown - Black

CAPITAL MEDICAL GROUP
Family Heart Imaging Occupational Aesthetics

CAPITAL AESTHETICS– 1001 Leawood Drive Suite A Frankfort KY 40601 ◊ 502.875.0872
www.capmedgrp.com

USE OF PHOTOGRAPHS

EXPLANATION:

This consent form authorizes this clinic and individual members of the clinic's staff to use photographs of pre-treatment, post-treatment, and treatment in progress for the purposes of teaching, research and as illustrations of typical expected results. Under no circumstances will any publication or material bear any name or personal identifier. Your refusal to consent to use these photographs for purposes other than medical record documentation will in no way influence your treatment.

CONSENT:
I understand the photographs taken of me shall be used for documentation in my medical record and if in the judgment of the medical health care professional, medical research, education or science will be benefited by their use, such photographs and information relating to my case may be published and republished, either separately or in conjunction with each other. In professional journals or medical books, or used for any other purpose which my health care professional may deem proper in the interest of medical education, knowledge or research.

I waive the rights that I may have to any claims for payment or royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless the clinic, staff and consultants from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the limitation: Under No circumstances will any such publication, film photograph, video or material exhibited contain my name unless voluntarily disclosed by me.

_____	_____
Signature of Patient	Signature of Witness
_____	_____
Printed Name of Patient	Printed Name of Witness
_____	_____
Date	Date