CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name ______________________________Today's Date ______________
Date of Birth ________________ Age _____ Occupation ________________
Home Address ___________________ City ___________ State _____ Zip Code _____
Phone: Day (___)______________Cell (___) __________ Evening ( ) __________
Email address______________________________________
Emergency Contact Name and Phone_________________________
Whom can we thank for referring you to us?_____________________
I would like to receive quarterly email newsletters with specials / sales? ❑ Yes ❑ No
I will notify Dr. Ling of any changes in my address, home or work phone numbers. ❑ Yes ❑ No

MEDICAL HISTORY

Are you currently under the care of a physician? ❑ No ❑ Yes: Dr. ______________
If yes, for what: ______________________________

Have you ever had an **allergic reaction**? (List any and all that you have had, and describe the reaction) ❑ None
❑ Food ❑ Latex ❑ Animal Protein ❑ Aspirin ❑ Lidocaine ❑ Hydrocortisone ❑ Botox ❑ Fillers
❑ Hydroquinone or skin bleaching agents ❑ Iodine ❑ Eggs ❑ Others**:** ______________

Do you have or have had any of the following **medical conditions**? (Please check all that apply)
❑ Herpes /cold sores ❑ Diabetes ❑ HIV/AIDS ❑ Hepatitis ❑ Steroid therapy ❑ High blood pressure
❑ Anticoagulation therapy (aspirin, warfarin) ❑ Blood clotting abnormalities ❑ Pacemaker/defibrillator
❑ Seizure disorder ❑ Tattoo or permanent makeup ❑ Varicose veins ❑ Metal implants ❑ Porphyria
❑ Any active infection ❑ Keloid scarring ❑ Skin disease/Skin lesions ❑ Menstrual disorders (irregular periods)
❑ Hormone imbalance ❑ Thyroid imbalance ❑ MTHFR ❑ COVID-19 ❑ Anxiety ❑ Depression ❑ Mental Disorder
❑ Cancer______________❑ Skin Cancer (BCC, SCC, melanoma) ❑ Radiation therapy ❑ Chemotherapy
❑ None of the above ❑ Other: ______________________

Surgeries: ❑ No ❑ Yes: ______________________
First day of last menstrual period: __________ ❑ Menopause_____❑ IUD ____ Pregnancies ____ Births
Are you pregnant or trying to become pregnant? ❑ Yes ❑ No Are you breastfeeding? ❑ Yes ❑ No

Social: Do you smoke / vape? ❑ No ❑ Yes. If so, ______________ ❑ cigarettes / ❑ packs per day
Coffee ________ cups/day Tea ________ cups/day Soda ________ cups/day Water ________ cups/day
Alcoholic beverages ________ servings / day ______ days / week Special Diet: ❑ Vegan/vegetarian________
Do you regularly sun bathe or exercise in the sun? ❑ Yes ❑ No How often?______________
How often do you exercise?______________ ❑ Cardio ❑ Weight Training ❑ HIIT ❑ __________
When do you plan to be exposed to the sun again?______________________
Do you have any upcoming social events? ❑ No ❑ Yes: ______________________

Where does skincare fit into your day? ❑ once daily ❑ twice daily ❑ other ______________
What products do you use? ❑ Cleanser ____________ ❑ Toner ______________
❑ Serum ______________ ❑ SPF ______________ ❑ Moisturizer ______________
❑ Products containing glycolic, lactic, or any hydroxy acids ______________❑ Retinoid __________
❑Cosmetics ______________

Client Name: ____

MEDICATIONS

What prescription medications are you presently taking? ❑ Birth control pills ❑ Hormone replacement ❑ IUD

____

❑ Others (please list): ____

Have you ever used Accutane? ❑ Yes ❑ No. If yes, when did you last use it? ______________________________

What topical medications or creams are you currently using? ❑ Retinoid ❑ Others (Please list):________________

Herbal supplements? ____

COSMETIC HISTORY

Previous cosmetic procedures? ❑ None ❑ Microdermabrasion ❑ Chemical Peel ❑ Neuromodulators ❑ Dermal Fillers
❑ Laser Treatments ❑ Threadlift ❑ Dermaplaning ❑ Microneedling ❑ Waxing / Sugaring ❑ Body Sculpting
❑ Other: ____

Describe previous procedure success / problems: ____

Have you had any recent tanning or sun exposure that changed the color of your skin? ❑ Yes ❑ No

Have you recently used any self-tanning lotions or treatments? ❑ Yes ❑ No

Do you form thick or raised scars from cuts or burns? ❑ Yes ❑ No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❑ Yes ❑ No If yes, please describe: ____

SKIN TYPE

Which best describes your skin type?

❑ I Always burns, never tans
❑ II Always burns, sometimes tans
❑ III Sometimes burns, always tans
❑ IV Rarely burns, always tans
❑ V Brown, moderately pigmented skin
❑ VI Black skin

My Concerns: *(please check all that apply)*

❑ Wrinkles ❑ Acne ❑ Scars / keloids ❑ Skin growths
❑ Brown spots / melasma ❑ Sagging skin ❑ Volume loss
❑ Spider veins / rosacea. ❑ Thinning lips ❑ Hollow undereyes
❑ Yellow teeth ❑ Thinning hair ❑ Unwanted hair
❑ Jowls ❑ Double chin ❑ Unwanted fat ❑ Cellulite
❑ Urinary incontinence ❑ Vaginal laxity/dryness ❑ Enlarged pores
❑ Unwanted tattoo / PCM ❑ Other: ____________________________

I certify that the preceding medical, medication and personal history statements are true and correct. I am aware that it is my responsibility to inform the doctor or other health professional of my current medical or health conditions and to update this history. A current medical and social history are essential for the caregiver to recommend and execute appropriate treatment procedures.

I understand there are no expressed or written guarantees for any of the procedures or medical treatments I receive. I certify that I have read the provided consent and I fully understand it. The nature and purpose of the treatment options have been explained to me.

Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for full payment at the time of service.

Before and after treatment instructions have been discussed with me. I have received a copy of the aftercare instructions, and it is available on the website. The procedure, as well as potential benefits and risks, have been explained to my satisfaction. I have had all my questions answered.

I release Dr. Shirat Ling, Innate Beauty Medical Spa, and its staff from all liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This Consent Form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. This constitutes the full disclosure and supersedes any previous verbal or written disclosures.

Signature __________________________Printed Name______________________________Date: _________

Parent / Guardian Signature:_______________________________Date:_______________________________

Witness____Date:_______________________________

CLIENT INFORMATION & MEDICAL HISTORY

Client Name: ________________________________ Date: ___________________________________

Patient consent and acknowledgement of receipt of privacy notice
I understand that as part of the provision of healthcare services, Innate Beauty creates and maintains health records and other information describing among other things: my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. Dr. Shirat Ling takes your confidentiality seriously.

By initialing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made based on my prior consent. This consent is given freely with the understanding that:

______ Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment, or health care operations without any prior written authorization, except as otherwise provided by law.

______ A photocopy or fax of this consent is as valid as this original.

______ I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment, or health care operations, be restricted. I also understand that the practice and I must agree to any restriction in writing that I request on the use and disclose or my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_______If I discuss my treatment with any third party or on any public forum, such as social media, I give Dr. Ling permission to respond in that forum, and, in so doing, I waive and nullify all my confidentiality rights.

Consent to Treatment and Financial Responsibility

______ I consent to the medical / surgical procedure(s) and treatment(s), including but not limited to anesthesia, laboratory procedures, examinations to be rendered pursuant to the general and special instructions of my physician.

______ I acknowledge that I am legally responsible for all charges in connection with the medical and cosmetic treatment provided by representatives of Innate Beauty.

______ I understand my insurance carrier or health savings accounts may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, and lack of authorization or medical necessity. I understand I am responsible for fees not paid in full, co-payments, policy deductibles, and co-insurance except when my liability is limited by contract State or Federal laws.

______ Payment is expected in full at the time of service. Patients may pay by Visa, Mastercard, Discover, Amex, Cash, Venmo, Zelle, Care Credit, or personal checks. Personal checks are not accepted with the initial visit. There is a $25 charge on all returned checks; $50 charge for canceled credit cards. There is a 10% fee added to each Care Credit transaction; I am responsible for all balance and fees due, if I default on my Care Credit payments.

_____ All prices are subject to change without prior notice

Cancellation Policy and Called-in Prescriptions

_______A 24 hour notice is required to reschedule or cancel an appointment. If 24 hours notice is not given, a charge of $50.00 per office visit will be assessed on your account. Confirmation emails are made as a courtesy to each patient when possible. Our inability to contact you to confirm your appointment does not constitute an exemption from our cancellation policy. As a courtesy to all patients on time for their appointments, anyone being 15 minutes late or more will need to reschedule their appointment, and pay the no-show fee. After the second no-show, the full price of the procedure will be charged to reserve future appointments and is non-refundable in the event of a no-show.

_______A $50 fee is charged when Dr. Ling is contacted for a prescription, without an office visit / procedure.

_______A $50 fee is charged for email, text, or phone communications exceeding two interactions, per interaction.

Signature _______________________________________Witness:____________________Date: _______________
Parent / Guardian Signature:______________________________Date:____________________________________

Use of Photographs for Medical Education, Science or Research

Explanation

This consent form authorizes this clinic and individual members of their clinic's staff to use these photographs and/or video footage for medical education teaching or research. Under no such circumstances will any publications or material bear your name. Your refusal to consent to the use of these photographs for medical education teaching or research will in no way influence your treatment.

Consent

I understand the photographs / videos taken of me shall be used for medical records 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 following limitation:
Under no circumstances will any such publication, film photograph, video tape or material exhibited contain my name unless voluntarily disclosed by me.

❑ I consent to use of photographs for medical records only, unless Dr. Ling crops the image to protect my identity, and I give consent prior to sharing.

______________________________	______________________________
Signature of patient	Printed Name
______________________________	______________________________
Signature of Parent / Guardian	Printed Name
______________________________	______________________________
Signature of Witness	Date