Dear Patient:

Welcome to Quality of Life Aesthetics, LLC (QLA). We would like to welcome you to our practice and to make your visit with us as comfortable as possible. We would like to take this opportunity to answer some questions frequently asked by new patients.

CLINIC HOURS: Monday through Friday 8:00am to 5:00pm

APPOINTMENT POLICY: Due to the high demand for appointments, all appointments must be cancelled at least 24 hours in advance. We reserve the right to add a $25 charge to your account for missed appointments or those cancelled less than 24 hours in advance. As a reminder, we ask that all patients arrive at least 15 minutes before their scheduled appointment time so we can review all documents.

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You will find the following forms in your New Patient package. Please have them filled out and signed prior to your first visit along with your I.D.

- **PATIENT DEMOGRAPHICS:** Include all of your current personal information.
- **PATIENT RESPONSIBILITY:** You will be financially responsible for all services or fees incurred with this visit.

TO SUMMARIZE YOUR FIRST VISIT, PLEASE BRING THE FOLLOWING ITEMS:

a. the enclosed forms completed to the best of your ability.
b. drivers license or some form of Photo ID

You will need to arrive **15 minutes early for a new patient appointment** so the front desk can process all of your information.

QUALITY AESTHETICS LASER

New Patient Registration

Name:		Date:
Date of Birth:		
Address:		City, State, Zip
Phone:		Cell:
E-mail Address:		Referred By:
Are you: ☐ Single, ☐ Married, ☐ Widowed		
Employer:		Occupation:

What would you like to achieve from your visit today? _____

Please list all allergies: _____

Please list all medications (including over the counter): _____

_____

Does your job require work outdoors? Yes ☐ No ☐

History

Have you ever had Bont-A, Filler (i.e., Restylane, Juvederm) or Collagen Injections? Yes ☐ No ☐
If yes, please specify: _____

What was your reaction? Positive ☐ Negative ☐
If negative, please explain: _____

Have you ever had facial treatment before? Yes ☐ No ☐
If yes, what type: _____ When: _____

Have you ever received; Laser, IPL or radio frequency treatments? Yes ☐ No ☐
When? _____

Have you ever had chemical peels, laser or micro-dermabrasion? Yes ☐ No ☐ In last month ☐

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products?
Yes ☐ No ☐
Describe: _____

QUALITY AESTHETICS LASER

Which of the following describes your skin type? (Please check one)

- ☐ I Creamy complexion: Always burns easily, never tans
- ☐ II Light Complexion: Always burns, tans slightly
- ☐ III Light/Matte Complexion: Burns moderately, tans gradually
- ☐ IV Matte Complexion: Seldom Burns, always tans well
- ☐ V Brown Complexion: Rarely burns, deep tan
- ☐ VI Black Complexion: Never burns, deeply pigmented

Do you have special skin problems or concerns pertaining to your face or body? Yes ☐ No ☐
Specify: _____

Do you have a history of cold sores? Yes ☐ No ☐

Have you ever used an acne medication? Yes ☐ No ☐
If yes, when: _____ Drug type: _____

Have you recently used any self-tanning lotions, creams or treatments? Yes ☐ No ☐
If yes, specify: _____

Have you ever used any of the following hair removal methods in the past six weeks? Yes ☐ No ☐
If yes, check all that apply:

- ☐ Shaving
- ☐ Waxing
- ☐ Electrolysis
- ☐ Plucking
- ☐ Stringing/Threading
- ☐ Depilatories

What areas of concern do you have regarding your skin?
Check all that apply:

- ☐ Dry Eyes ☐ Puffiness ☐ Dark Circles ☐ Other: _____
- ☐ Dry/Cracked/Chapped Lips ☐ Other: _____
- ☐ Breakouts/Acne
- ☐ Blackheads/Whiteheads
- ☐ Excessive Oil/Shine
- ☐ Rosacea
- ☐ Broken Capillaries
- ☐ Redness/Ruddiness
- ☐ Sun Spot/Liver Spot/Brown Spot
- ☐ Uneven Skin Tone
- ☐ Sun Damage
- ☐ Wrinkles/Fine Lines
- ☐ Dull/Dry/Flaky Skin

Do you use:

SPF on face? Yes ☐ No ☐ How often/What strength: _____
A Clarisonic Ultrasound brush: Yes ☐ No ☐
Galvanic spa or Microcurrent? Yes ☐ No ☐

What skin care products are you currently using? (List brand where known)

☐ Soap	☐ Toner	☐ Cleanser	☐ Mask
☐ Day Moisturizer	☐ Exfoliate	☐ Scrubs	☐ Shower Gels
☐ Body Lotions	☐ Eye Product	☐ Sunscreen/SPF: _____	
☐ Makeup Products	☐ Night Moisturizer	☐ Other: _____	

Have you ever had any recent tanning bed or sun exposure that changed the color of your skin?
Yes ☐ No ☐ Specify: _____

Female Clients Only

Are you taking oral contraceptives? Yes ☐ No ☐ If yes, specify: _____

Have there been any recent changes in contraceptive treatment? Yes ☐ No ☐
If yes, specify: _____

Are you pregnant or trying to become pregnant? Yes ☐ No ☐

Are you lactating? Yes ☐ No ☐

Have you begun menopause? Yes ☐ No ☐ Specify: _____

Are you undergoing any hormone replacement therapy?
Yes ☐ No ☐ Specify: _____

Male Clients Only

What is your current shaving system? Wet shave ☐ Electric ☐

Do you experience irritation with shaving? Yes ☐ No ☐

Are you susceptible to ingrown hairs? Yes ☐ No ☐

PERMISSION TO RELEASE INFORMATION

I, _____ hereby give my consent to release information to:

Name: _____Relationship:_____Phone:_____

ADDITIONAL CONTACTS

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

CHECK ALL THAT APPLY

_____ Contact in case of an emergency

_____ Leave message with _____ Phone: _____

PLEASE LIST ANY INFORMATION YOU WOULD NOT WISH TO BE RELEASED AND TO WHOM:

_____

_____

_____

OK TO LEAVE MESSAGES ON:

Home phone: _____ Mobile Phone: _____

Work Voice Mail: _____ Other: _____

This form will be kept in your medical file until you notify us of any changes you would like us to make

Signature: _____ Date:_____

HIPAA Policy

This notice describes how health information about our patients 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.

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES: The following circumstances may require us to use or disclose your health information:

- To public health authorities/health oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a law enforcement official.
- 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.
- If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security activities authorized by law.
- To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
- For Workers Compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

- You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
- You can request a restriction in our use or disclosure of your health information for treatment, payment or healthcare operations. 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 required by law, in emergencies, or when the information is necessary to treat you.
- You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Compliance Officer at (520)733-2250 who will have up to 30 days to comply.
- You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Compliance Officer at (520)733-2250 who will have 60 days to respond. You must provide us with a legitimate reason that supports your request for amendment.
- You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy of this notice by contacting our front desk receptionist.
- If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint, contact the Compliance Officer at (520)733-2250. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact your physician.

FINANCIAL POLICY

All elective procedures must be paid in advance or on the day of service, unless payment arrangements have been agreed upon by the billing department.

PAYMENT ARRANGEMENTS AND COLLECTION: It is your responsibility to make payment for services rendered.

IMPORTANT REMINDER ABOUT APPOINTMENT POLICY: Due to the high demand for appointments, all appointments must be cancelled at least 24 hours in advance. We reserve the right to add a $25 charge to your account for missed appointments or those cancelled less than 24 hours in advance. As a reminder, we ask that all patients arrive at least 15 minutes before their scheduled appointment time so we can review all documents.

If you are unable to make payment in full, it is important that you contact our billing office to make payment arrangements on your account. Anyone who is making regular payments on their accounts via a payment agreement will continue to receive all services provided by Quality of Life Aesthetics, LLC.

STATEMENTS: Payments should be mailed to 5390 E. Erickson Dr., Tucson AZ, 85712, attention "Billing Department". If you have any questions please call 520.495.4692.

If NO payment is received, or if payments are untimely, a collection agency may be utilized. No further services will be utilized until the balance due is paid to our billing department.

PLEASE NOTE: Patients, who have not made regular payments in three (3) months, and have not contacted our Billing Department to make payment arrangements, will be dismissed from the practice.

I have read and understand the financial policy of Quality of Life Aesthetics, LLC. I understand that I am personally responsible and liable for payment of any balance on my account.

_____ _____

Name Date