

**SANTA ANA SKIN CARE CLINIC  
683-B HARKLE RD  
SANTA FE, N.M. 87505**

**FIRST NAME:** \_\_\_\_\_ **LAST NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**WORK #:** \_\_\_\_\_ **HOME #:** \_\_\_\_\_

**SS#:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**WHO REFERRED YOU TO OUR OFFICE?** \_\_\_\_\_

Thank you for choosing our office for all of your skin care needs. If at any time you have questions regarding your treatment please feel free to call the office. Please note that treatment fees are due at the time of services, and medical insurance does not cover treatments because they are considered a cosmetic luxury. Also note that the results of products and procedures are not guaranteed. Also all products and services offered through Santa Ana Skin Care Clinic are **non-refundable**.

\_\_\_\_\_  
SIGNATURE OF  
RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

# LASER HAIR REDUCTION MEDICAL HISTORY

## AURORA AND ALTUS LASER SYSTEMS

What is your chief complaint? \_\_\_\_\_

What past surgeries have you had? \_\_\_\_\_

Do you currently have or have you ever had any of the following?

Bleeding disorder	Yes ___ No ___	
Bruise easily	Yes ___ No ___	
Pigmentation disorder	Yes ___ No ___	
Cold Sores/Fever Blisters	Yes ___ No ___	Date of last exposure _____
Keloid scarring	Yes ___ No ___	
Dermatological conditions	Yes ___ No ___	Please specify _____
Endocrine/hormone issues	Yes ___ No ___	Please specify _____
Pacemaker/defibrillator	Yes ___ No ___	
Accutane	Yes ___ No ___	Date of last use _____
Skin Cancer	Yes ___ No ___	Date of last diagnosis _____
Photo allergic	Yes ___ No ___	

Please list any other medical conditions you may have. \_\_\_\_\_  
\_\_\_\_\_

Please list any/all medications you are currently taking. \_\_\_\_\_  
\_\_\_\_\_

Please list any/all allergies you may have. \_\_\_\_\_  
\_\_\_\_\_

Do you currently or have you ever done any of the following treatments?

Wax	Yes ___ No ___	Date of last exposure _____
Pluck	Yes ___ No ___	Date of last exposure _____
Electrolysis	Yes ___ No ___	Date of last exposure _____
Shave	Yes ___ No ___	Date of last exposure _____
Threading	Yes ___ No ___	Date of last exposure _____
Previous laser tx	Yes ___ No ___	Date of last exposure _____
Permanent make up	Yes ___ No ___	Date of last exposure _____
Restylane/collagen	Yes ___ No ___	Date of last exposure _____
Sun or tanning bed	Yes ___ No ___	Date of last exposure _____
Self-tanning lotion	Yes ___ No ___	Date of last exposure _____

Do you use deodorant?      Yes \_\_\_\_ No \_\_\_\_

**Contraindications:**

- Pacemaker
- Accutane taken in last 6 months
- History of keloid scarring
- Abnormal or undiagnosed pigmentation should be avoided
- Atypical moles or malignancy
- Non-intact skin (i.e. sores, psoriasis, eczema, infection, rash) should be avoided
- Recent chemical or mechanical peeling in treatment area (within 2 weeks)
- Laser resurfacing in treatment area within 3 months
- Any medical condition involving impairment of skin structure, healing patterns
- Poorly controlled diabetes
- Pregnancy

**Precautions:** (Treat with caution if the patient has any of the following risk factors)

- Medications that may cause photosensitivity to light 680-980 nm
- Healing impaired
- History of skin cancer in treatment area, family history of melanoma
- Nickel allergy (Test patients that have known nickel sensitivity, the electrodes are nickel-plated)
- Wait 2 weeks before/after injectible or filler procedures in area

**Average number of treatments for satisfactory clearance: 4-8**

\*Poor target hair such as light or fine hair typically takes 8 or more treatments to achieve 50-70% reduction.

\*The above data is statistical average. Some patients may require less than average of more than average number of treatments, to achieve satisfactory clearance. Response to treatment varies depending on medical factors, skin condition/type, and hair types. There is also a small percentage of idiopathic non-responders.

## **INFORMED CONSENT FOR AURORA/ALTUS LASER HAIR REDUCTION**

I hereby authorize and direct any associates or assistants of Santa Ana Skin Care Clinic to perform laser assisted hair reduction on me. I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one is unlikely, and I understand that I will require several treatments to obtain significant, long-term reduction of hair growth. I also understand some people may not experience complete hair loss even with multiple laser procedures.

I am aware of the following possible experiences/risks with Laser Surgery:

- \* Discomfort- Some discomfort may be experienced during laser treatment.
- \* Wound healing- Laser surgery can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.
- \* Bruising/Swelling/Infection- With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility, although rare, whenever a skin procedure is performed.
- \* Pigment changes- During the healing process there is a slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but on rare occasions, it may be permanent.
- \* Scarring- Scarring is a rare occurrence, but it is a possibility when the skin's surface is disrupted. To minimize the changes of scarring, it is important that you follow all post-treatment instructions carefully.
- \* Eye Exposure- Protective eye wear will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.

I understand that results may vary in from person to person. Results may vary depending on individual factors, including medical history, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment.

Initials \_\_\_\_\_

I understand that there is a possibility of short-term effects such as reddening, mild blistering or scabbing, temporary bruising, and temporary discoloration of the skin; as well as the possibility of rare side effects such as scarring and permanent discoloration.

Initials \_\_\_\_\_

By my signature below, I certify that I have read and fully understand the contents of this form. I understand that no guarantee can be given as to the final result obtained.

\_\_\_\_\_

\_\_\_\_\_

Signature

Date

## PROCEDURE AGREEMENT FORM

- \_\_\_\_ Initials Prior to receiving treatment, I have been candid in healing any condition that may have bearing on this procedure, such as: pregnancy, recent facial surgery, allergies, cold sores/fever blisters use of medication, etc.
- \_\_\_\_ Initials I understand there may be some degree of discomfort, i.e.: stinging, pin pricking, hotness, tightness, etc.
- \_\_\_\_ Initials I understand there are no guarantees as to the results of this treatment, due to Many variables, such as: age, condition of skin, smoking, etc.
- \_\_\_\_ Initials I understand that I may or may not actually peel, that each case is individual.
- \_\_\_\_ Initials I understand that the treatments performed here are considered cosmetic, and there can be no guarantees of insurance payment.
- \_\_\_\_ Initials I understand that to achieve maximum results, I may need several treatments.
- \_\_\_\_ Initials I understand that although complications are very rare, they may still occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor or aesthetician who performed the treatment.
- \_\_\_\_ Initials I agree to refrain from tanning booths while I am undergoing treatment, and during the 21 days following the end of treatment.
- \_\_\_\_ Initials I understand that direct sun exposure is prohibited while I am undergoing treatment, and the use of sun block with a minimum SPF 15 is mandatory.
- \_\_\_\_ Initials I have not had any other peel treatment of any kind within 14 days of this treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or at any other location, unless directly expressed otherwise by the doctor or aesthetician.

**I hereby agree to all of the above statements and have answered true and to the best of my knowledge. I give consent to have treatment performed on me. I further agree to follow all post care instructions as I am directed.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## FINANCIAL POLICY

Please read our financial policy and indicate your agreement by your signature. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. All patients must complete the appropriate information forms before seeing a skin care provider.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE.** (Unless other arrangements are made directly with the office manager.)

We accept cash, check, Visa, American Express, Discover and Master card.

Private pay patients: Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or paid by cash, check, or credit card at the time of services.

Insured patients: If you have insurance we will help you receive maximum benefits. We will give you properly completed “super bills” so that you can file your own insurance and be reimbursed to the extent of your coverage. We only file claims to insurance companies that we are participating providers for. Filing a claim is not a guarantee of payment. Many of our services are considered to be a cosmetic luxury and are therefore not covered by insurance. You are responsible for the full payment of any denied claims.

Insurance: This is a contract between you and your insurance company. In many cases we are not a party to this contract. We will inform you if we are a party to your contract, and we will handle your claims according to our agreement with your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance usual and customary charges, etc. other than to supply actual information as necessary. You are responsible for timely payment on your account.

**Missed appointments: Unless canceled or rescheduled at least 24 hours in advance, our policy is to charge \$50 for missed appointments. Please help us serve you better by keeping scheduled appointments.**

Balance due terms: Your signature below indicates your agreement with our terms for any unpaid balance due. Unpaid balances due will begin accruing interest at the rate of 12% per annum, for balance due over 30 days. If it becomes necessary to employ an attorney or collection agency to collect an unpaid balance due, those fees will be added to the balance due. If you are unable to pay a balance due, please discuss payment arrangements with our office manager.

Please Note: All products and services offered through Santa Ana Skin Care Clinic are non-refundable.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PRIVACY POLICY**

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice summarizes how we handle your information, and provides further details of our privacy policies and procedures.

**How we may use and disclose your information:** We use health information about you for your treatment, to get paid for treatments, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for these reasons. Beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop further uses or disclosures.

**Your rights:** In most cases you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we will charge you a cost-based fee and these copies will be made within 30 days. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

**Our legal duty:** We are required by law to protect the privacy of your health information; provide this notice about our privacy policies; follow the privacy practices that are described in this notice; and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make significant changes in our privacy policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

**Privacy complaints:** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

**If you have any questions or complaints, please contact:**

Elena Winters  
683 B Harkle Road  
Santa Fe, NM 87505

(505) 954-4422 ext 1004

Responsible party signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PROCEDURE CLAIM REVIEW FORM**

Santa Ana Skin Care Clinic would like to make you aware that in the in the event that we should submit a claim to your insurance company for a procedure reviewed here at our clinic, your insurance provider always reserves the right to review and deny any claim they receive. We may be able to find out for you if the procedure does not require a pre-authorization, but these procedures are still subject to review and possible denial. The only time your insurance company is obligated to pay any amount is if they give you a confirmed pre-authorization number which we will keep in your chart making you not responsible for payment; unless the treatment amount is applied towards a deductible then you will still be held responsible for payment. Your signature below indicates you agree to abide by the policy in this form.

I \_\_\_\_\_ have read and understand the Insurance Procedure Claim Review Form.