Pure Beauty
MEDICAL SPA

Patient Information

Last Name: _____ First Name:_____ DOB:_____

Cell Phone:_____ Home Phone:_____E-mail: _____

Address:_____

City: _____ State: _____ Zip:_____

Emergency Contact Information:

Name: _____Phone Number:_____

Whom may we thank for referring you? _____

Patient History

Are you pregnant, nursing, or planning a pregnancy soon? Yes / No

Do you have any concerns with the following? (Please circle)

Fine lines/Wrinkles	Skin Rejuvenation	Thin Lips
Thin Lips	Facial Fullness	Neck Wrinkles
Brown Age/ Sun Spots	Blotchy Skin	Large Pores
Length of Eyelashes	Fullness of Eyelashes	Darkness of Eyelashes
Unwanted Hair	Acne Scars	Abdominal Area

Have you ever had any laser treatments? Yes / No
If yes, when?_____

Have you ever had Botox or filler? Yes / No
If yes, when?_____

Do you have any history of the following? (Please circle)

Heart Disease	Diabetes	Cold Sores/Fever Blisters
Bleeding Disorders	Excessive Bruising	Dark Spots After Pregnancy
Skin Injury	Skin Cancer/ Suspicious Moles	Abnormal Scarring

Have you had any allergic reactions to topical or dental anesthesia? Yes/ No

Do you have any sensitivity to Lidocaine? Yes/No

Do you have any skin related allergies? Yes/No
If yes, please specify_____

Do you have any allergies to medication? Yes/No
If yes, please specify_____

Are you taking any of the following? (Please circle)

Aspirin/ Ibuprofen	Anti-coagulants (blood thinners)
Hormones/ Contraceptives	Appetite depressant/ Diet pills
Thyroid medication	Insulin
Sedatives	Tranquilizers
Cortisone	Accutane within the last 6 months
Hydroquinone (Bleaching)	Retin A
Vit/ Herbal supplements	Oral/ Topical Medication

PLEASE LIST ALL CURRENT MEDICATIONS_____
_____
_____
_____

Do you drink alcohol? Yes / No
If yes, how many do you consume on an average day?_____

Do you wear contact lenses? Yes / No

Mark your skin type (When exposed to the sun for a prolonged period of time with no protection.)

I	Always burns, never tans	
II	Always burns, sometimes tans	
III	Sometimes burns, sometimes tans	
IV	Always tans	
V	Asian, Hispanic, Mediterranean, Middle Eastern	
VI	Black	

When was the last time you were exposed to the sun? _____

Do you use self-tanners or go to a tanning bed? Yes / No
When was the last time?_____

Are you planning a holiday in the sun? Yes / No

Pure Beauty
MEDICAL SPA

Spa Policies

- When reserving an appointment, please inform that staff if you are pregnant or taking any antibiotics.

- We require all patients to check in 15 minutes prior to their appointment time. (30 minutes maybe required when the procedure requires numbing cream.)

- If you are running late we will do our best to complete the treatment but it may be necessary to reschedule. All appointments will end on time in order to be fair to our other patients.

- **Cancellation Policy:** We require 24 hour notice for all cancellations. If 24 hour notice is not provided then the treatment will be forfeited or a $50.00 fee will be required. There is an answering service that will take messages after hours and on weekends.

- Unopened products may be returned within 14 days with a receipt. Series, packages, and gift cards are NON-REFUNDABLE but we would be happy to give you credit towards our other services.

- We accept cash, Visa, Mastercard, Discover, Amex and Chase Health Advantage. All payments are due at the time of service.

_____ _____

Signature Date

Patient Photographic Authorization and Release

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 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 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 medial 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 Pure Beauty Skin Care, Inc. and its staff 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 request for any photographs to be used for my medical records only.

_____	_____	_____
Signature of Patient	Printed Name	Date

Acknowledge of Receipt of Privacy Notice for

Pure Beauty Skin Care, Inc.

200 Newport Center Drive #110
Newport Beach, CA 92660
Phone (949) 524-8036

Patient Name:_____ Date of Birth:_____

We are required by law to make available to you a copy of our Notice of Privacy Practices. A copy is available for you at the reception window and you may take this copy with you if desired.

Please sign below to acknowledge that a copy of our privacy practices was made available to you.

_____ _____
Signature of Patient or Legal Guardian Date

You may authorize certain individuals to be involved in your care. This consent for disclosure includes both health and financial as it relates to your care. Below you may list those individuals for which our office is allowed to release your Protected Health Information.

Individual's Name (Please Print) Relationship to Patient

_____
_____
_____
_____

_____
Signature Required for Permission Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All claims Must be Arbitrated**: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership and the employees, agents and estates of any of them, must be arbitrated, including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect the assertion of any claim, against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below. Effective as of the date of first medical services.

_____

Patient's or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BYNEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THISCONTRACT

By:_____ By:_____

Pure Beauty Skin Care, Inc. Date Patient's Signature Print Name (Date)