CLIENT INFORMATION & MEDICAL HISTORY DATE:

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

PERSONAL HISTORY

Name: _____ Email:_____

Street Address: _____

City: _____ State:____ Zip Code:_____

Phone number for appointment reminders/messages: _____

Emergency Contact Name and Number: _____

Would you like to receive our email promotions? Yes No

How did you hear about Skin 365?_____

Who is currently providing your skin care (facials, derma planning, etc.)?_____

MEDICAL HISTORY

Birth Month/Day/Year: _____

Are you currently under the care of a physician? Yes No
If yes, for what?_____

What medication(s) are you currently taking? _____

Any known drug allergies? Yes No Please list: _____

Have you ever had a skin allergy? _____

Do you have a history of allergies to gram-positive bacterial proteins? Yes No

Do you have history of Keloid scarring? Yes No

Have you had previous cosmetic injections? Yes No

If yes, what product? Restylane Botox Dysport Juvederm Radiesse Perlane Sculptra
When was the last time you had this injection?_____

Are you allergic to eggs or egg products? Yes No

Are you allergic to milk or milk products? Yes No

Have you ever had a reaction to lidocaine from local numbing (ex: Dental block)? Yes No

Are you using Retin A, Hydroquinone (Bleaching Cream), Glycolic Acid, Accutane or

any medication that could cause sun sensitivity? Yes No

If you have taken Accutane, when did you last use it? _____

Have you recently had a peel (chemical, acid, fruit, microdermabrasion)? Yes No

Have you had any laser or photofacial treatments? Yes No When?_____

Have you ever had a cold sore/herpes virus? Yes No If so where? _____

Could you be pregnant? Yes No Are you breastfeeding? Yes No

Do you have a history or Diagnosis of Auto Immune Disorder, Numbing of Extremities, Diabetes, or Seizure Disorder, cardiac history, or pacemaker impant? Yes No

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 sunbed treatments? Yes No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No

Do you have permanent cosmetic tattoos? Yes No
If so, where? Eyebrows Eyeliner Lip Liner Beauty Mark Enhancement

Do you have any freckles, moles, or a skin condition that has caused concern? Yes No

Have you seen a dermatologist or doctor for a skin check in the past year? Yes No

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the doctor or the nurse of my current medical or health conditions and to update this history with each appointment.
A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Cancellation Policy:
In addition, Skin 365 has a 24 hour cancellation policy. If I do not cancel my appointment at least 24 hours prior to the appointment, I agree to pay a missed appointment fee of $100.00

Signature:_____Date:_____

Registered Nurse:_____Date:_____
Office use only Skin Type: Allergies: Contraindications:
Alternative Methods Discussed: Photograph Documentation: MD approved:

Skin 365
Office of Michael Newman M.D.
4201 Torrance Blvd Suite 365 Torrance, CA 90503
(310) 316-3365

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Information Portability and Accountability Act, defines these privacy practices explicitly. It also requires us to give you a basic summary of them and obtain your acknowledgement that you have received this notice.

• The law permits us to disclose your health information to those involved in your care. For example, we In our office, we have always kept your health information confidential. A new law, HIPAA or Health may forward lab results to specialists you are seeing.

• We may disclose your health information for payment purposes. For example, we may send a copy of your office visit notes to your insurance company if they request it to verify payment.

• We may disclose your health information for our normal health care operations. For example, we may send a copy of your office visit notes to your insurance company to obtain authorization for non-formulary medications.

• We may disclose your information to contact you. For example, we may call you to remind you of appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the phone.

• In an emergency, we may disclose your health information to a family member or another person responsible for your care. In the event of a disaster, we may disclose information to a relief organization. If you are able and available to agree or object, we will give you the opportunity to do so before a disclosure is made; however, we may disclose this information in a disaster over your objection if we believe it is necessary to respond to the emergency circumstances.

• We may release some or all of your health information when required by law. For example, the law requires us to report abuse or domestic violence to law enforcement officials.

• If this practice is sold, the records will become the property of the new owner. You have the right to request that copies of your health information be transferred to another physician.

• Except as described above, this practice will not use or disclose your health information without your prior written authorization.

• You may request in writing that we not use or disclose your health information as described above. We will let you know whether we can fulfill your request.

• You have the right to know any disclosures we make beyond the above normal uses.

• You have the right to request that we contact you only at specific telephone numbers or addresses. We will comply with all reasonable requests submitted in writing.

• You have the right to transfer copies of your health information to another practice.

• You have the right to inspect and/or copy your health information. To access your health information, you must submit a written request detailing what information you want and whether you wish to inspect or copy it. If you would like us to provide the copies, we will charge a reasonable fee, as allowed by law.

• There are a few exceptions to your right to access records. For example, we may deny your request to access your child's records if we believe that allowing access would be reasonably likely to cause substantial harm to the patient. If we deny your request, you have a right to appeal.

• You have the right to request that we amend your health information if you believe it is incorrect or incomplete. You must submit a written request. We are not required to make the changes you request, but we will include your statement in your file.

• If you received this notice electronically, you have a right to request a copy of this notice in paper form.

• We reserve the right to amend this notice. If we do, a copy may be requested at your next appointment.

• If you believe we have not handled your health information appropriately, you may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be penalized for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, JoLyn Gibb at 310 316-3365

Signature of Patient:_____ Date:_____ effective 05/01/08

4201 Torrance Blvd #365 Torrance, CA 90503 (310) 316-3365

Appointment Cancellation Policy

New Client Forms e All new clients are are required to fill out new patient information forms. e

Parking e We will validate the first hour of parking in the lot reserved for 4201. e

Late Arrivals e Your appointment is reserved especially for you. Should you need to cancel or change the date of your appointment, we require at least 24-hours notice as a courtesy to other patients seeking appointments.

A late arrival will deprive you of your treatment time. In fairness to other patients, if your arrival is delayed by 10 minutes or more --- we may not be able to accommodate you on that day -- and a **late cancellation fee** will apply. Your treatment must end on time so that other client's sessions can begin as scheduled. e

How To Cancel Your Appointment

As our reserved appointments are held exclusively for you, we request a 24 hour cancellation notice. Same day cancellations and no-shows will be charged a $100 fee for holding the room and the specialist's time. e

To cancel appointments please call (310) 316-3365 or (310) 933-2523. If you do not reach the receptionist you may leave a detailed message on the voicemail. An alternate choice is to send an email to skin365@gmail.com

Late Cancellations

Late cancellations will be considered as a "no show". No-shows will be charged a $100 fee for holding the room and the specialist's time. e

No Show Policy

A "no show" is someone who misses an appointment without canceling it by 10a.m. one (1) working day in advance.

A failure to be present at the time of a scheduled appointment will be recorded in the patients chart as a "no show". For any "no show" the patient will be sent a letter to the their home alerting them to the fact that they have failed to show up for a scheduled appointment and a fee of $100 dollars will be billed to their account.

e Patient Signature_____

Patient Name (Printed)_____ Date _____

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Office of Michael K. Newman M.D.

Consent and Release

I acknowledge that the practice of skin care and advanced medical aesthetic treatments including facials, advanced acid peels, dermaplaning, laser treatments: Intense Pulsed Light devices with Radio-Frequency, dermal injections for wrinkle correction and upper facial contouring, and carious other beauty treatments are not an exact science and no specific guaranties can or have been made concerning expected results. I understand that some clients experience more change and improvements than others. In virtually all cases, multiple treatments are required in order to realize a difference.

I also realize that the following risks and hazards may occur I connection with any particular treatment- including but not limited to: unsatisfactory results, poor healing, discomfort, redness, blistering, nerve damage, scarring, change in the skins pigment, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. I also agree to hold harmless and release from any liability Medi-Rejuvenation Corporation doing business as Skin 365 or any of its officers, medical directors (Michael K. Newman M.D.), employees and independent contractors (JoLyn Gibb RN, Lisa Sanchez L.E., Bridgette Bambrick L.E.) any condition or result, known or unknown that may arise as a result of any treatment that I receive.

_____ _____
Client's name (Print) Date

_____ _____
Signature Practitioner's initials

Skin 365
Michael Newman MD
JoLyn Gibb RN
4201 Torrance Blvd Suite 365
Torrance, California 90503
(310) 316-3365

This consent form authorizes Skin 365, to use your photographs for medical education, teaching, or research. Your refusal to consent to the use of your photographs will in no way influence your treatment.

I prefer that the photographs taken of me shall be used for my medical records only. I do not give permission to use my photographs in any other way other than my records.

I consent that the photographs taken of me may be used for marketing, medical research, education, or scientific purposes. I understand that 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, research, or marketing. I understand that whenever possible, my identity will attempt to be masked with the use of cropping, or blocking out of distinguishing features.

I waive any 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 under no circumstances will any such publication, film photograph, video tape or any material will contain my name unless voluntarily disclosed by me.

Signature of patient

Printed Name Date

Signature of practitioner