REFRESH | REFINE

New Client

First Name

_____

Last Name

_____

How I Heard About Modern Aesthetics

Today I am here for: Other _____

Options Include - Tox - Filler - AntiAging Medicine Consult - BioIdentical Hormone Consult - Digestive Health Consult - Weight Program Consult - Skin Rejuvenation - Laser Hair Consult - Skin Care Consult, MicroNeedling with PRP, PDO Threads, Other

Phone Number of Emergency Contact: _____

My Medical/Surgical history includes:_____

List of All Current Medications: _____

List of Medications I am Allergic to: _____

List of All Supplements: _____

When In the Sun I

◉ Burn First ○ Tan First

I have had Botox / Jeuveau / Dysport / Xeomin before

◉ Yes ○ No

If Yes, please say when and how many units if possible. Note any concerns : _____

I have had Filler before

◉ Yes ○ No

If yes, please say when and how many syringes and where if possible. Note any concerns

I have had Laser Hair Removal before

◉ Yes ○ No

If Yes, please say how many sessions and which areas. Note any concerns : _____

I am currently pregnant or nursing

◉ Yes ○ No

I have an AutoImmune condition (for example Rheumatoid, Lupus, M.S. or other)

○ Yes ◉ No

I do not abuse alcohol / drugs

◉ Yes

I agree to pay the full amount for services rendered at time of checkout

◉ Yes

I agree to inform my Provider if any of the above changes at subsequent visits

◉ Yes

OFFICE POLICIES

☐ It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unauthorized improperly, negligently or incompetently rendered, will be determined by submission to arbitration and not by a lawsuit or resort to court process, except as 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 binding

☐ In the event that 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 provisions. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL. (Refer to Article 1 of California Code of Civil Procedure sect 1295) I understand that I have the right to receive a copy of this arbitration agreement.

☐ It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may rise out of or in any way relate to treatment or services provided by Modern Aesthetics MD to a patient.

☐ I have or will provide full informed consent prior to receiving any treatment. This will be per written or verbal signature. I also understand that there are no 'guarantees' to the outcome of an aesthetic procedure and I hereby waive the right to seek a refund, partial or full, in the event that the desired outcome is not achieved

☐ Either party to this agreement may initiate arbitration by submitting a Demand for Arbitration in writing by US mail to the other. The demand shall contain a simple statement of the nature of the dispute, amount of damages sought, name and contact information of the patient and the remedy demanded. The arbitrator shall be selected by agreement of the parties on or before 30 calendar days of the postmark date that the demand for arbitration was mailed. There shall be a group of three arbitrators, who are usually retired judges of a court of record. If state the arbitrator's findings of fact and conclusions of law. The arbitrator's award shall be binding on the parties to the arbitration and judgment on the award may be entered by a court of competent jurisdiction in the state of record. Unless the arbitrators shall determine otherwise, the arbitration shall take place in the county where the services were rendered. The arbitrators shall have the authority to hear any claim and award any remedy that could otherwise be heard or rendered by the Superior Court of the state or a federal district court in that state.

☐ Payment for services are owed same day in full as day of service rendered. Methods of payment accepted include; Cash, Check, Major credit card (Visa, Mastercard, AMEX) and Debit card. We do NOT accept HSA/FSA cards as we do not work with insurance companies and do NOT claim our services are part of your medical benefits.

☐ Your information and records are stored in an electronic fashion with safeguards that are HIPAA compliant. As a business we follow the standards of privacy related to your information as required by the State of California

☐ I understand and voluntarily agree with the Refund Policy of Modern Aesthetics. There are no refunds, partial or full, for services provided. For services not yet rendered, I agree to accept a full refund less 10% per transaction. I also understand that there is no refund for unused product and that at the Provider's discretion, the optimal amount of product will be used. This applies to Injectables and other similar products dispensed in single use amounts. Modern Aesthetics takes every reasonable attempt to ensure that clients are satisfied with their treatments. In the case of lack of appropriate results Modern Aesthetics may offer additional treatment at no cost depending on a case by case basis.

☐ 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. An updated Privacy Policy is available in office on our website - see Footer This Notice of Privacy Practices describes how we may use and disclose your protected health/personal information (PHI) to carryout out treatment, payment or business operations (TPO) and for other purposes that are permitted or required by law. It also describes our rights to access and control your protected information. Protected health/personal information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. 1. Uses and Disclosures of Protected Health/Personal Information Uses and Disclosures of Protected Health/Personal Information Your protected health/personal information may be used and disclosed by our medical director, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to support business operations of this office, if requested by you to a finance company to pay for your care, and any other use required by law. Treatment: We will use and disclose your protected health/personal information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health/personal information, as necessary, if, as a result of our services, you require treatment by a physician. Your protected health/personal information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health/personal information will be used, if requested, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval. Healthcare Operations: We may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health/personal information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law, communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors and organ donation; research; criminal activity and national security; workersï¿½ compensation; inmates; required uses and disclosures. Under the law, we must make disclosure to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that this office has taken an action in reliance on the use or disclosure indicated in the authorization. 2. Your Rights Following is a statement of your rights with respect to your protected health/personal information. You have the right to inspect and copy your protected health/personal information. Under federal law, however, you may not inspect or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health/personal information that is subject to law that prohibits access to protected health/personal information. You have the right to require a restriction of your protected health/personal information. This means you may ask us not to use or disclose any part of your protected health/personal information for the purposes of treatment or healthcare operations. You may also request that any part of your protected health/personal information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request. If our medical director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your protected health/personal information will not be restricted. You then have the right to use another service provider. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically. You may have the right to amend your protected health/personal information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to our statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health/personal information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2009. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES I hereby acknowledge that I may receive a copy of this medical practice's Notice of Privacy Practices. It is available upfront in the office and on the website ModernAestheticsMD.com. I further acknowledge that a copy of the current notice will be posted in the reception area and available at each appointment We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health/personal information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number. Please note that this office offers communication regarding appointments via email and text. If you wish to NOT receive texts please inform a staff member immediately. Note the following warnings regarding communication via email and/or text. By signing this document I agree to send and receive texts regarding my appointments and treatments. I understand that this may not be fully secure and I can opt out of receiving or sending texts at any time by notifying the office in writing. WARNING: CONFIDENTIALITY NOTICE - The information enclosed with this transmission are the private, confidential property of the sender, and the material is privileged communication intended solely for the individual indicated. If you are not the intended recipient, you are notified that any review, disclosure, copying, distribution, or the taking of any other action relevant to the contents of this transmission are strictly prohibited. If you have received this transmission in error, please notify us immediately at 916 952 3248 Sample Email Security Warning To Patients Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed. Please do not include personal identifying information such as your birth date, or personal medical information in any emails you send to us. No one can diagnose your condition from email or other written communications, and communication via our website cannot replace the relationship you have with a physician or another healthcare practitioner. BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

☐ To protect the safety of Providers and Clients the premises are under recording. The video footage will not be shared without consent of client or by legal requirement. By entering Modern Aesthetics and receiving services I consent to be recorded. Any exposed body parts for purpose of treatment may be recorded.

☐ I understand that any Aesthetic treatment is associated with variabilities in outcomes and is not guaranteed to be of a certain efficacy or aesthetic outcome. I understand that 'Perfection' is not a reasonable or realistic goal.

☐ SCHEDULING POLICY A consultation is complementary However a credit card on file is needed in order to confirm your appointment A charge will be applied according to our Reschedule Policy and No Show Policy per below

☐ RESCHEDULE POLICY Appointments changed with less than 48 hours notice will be allowed only once during a course of treatment. Any subsequent reschedules less than 24 hours notice will be subject to a $100 fee each time - this fee will apply as credit towards a future service

☐ NO SHOW POLICY Please note a $100 fee for a missed appointment which will be charged for an appointment where no notification is received We look forward to seeing you

Signature

_____

Client Signature