Solé Medical Spa
NEW PATIENT/MEDICAL HISTORY FORM

Name:______________________________________ Date: _________________________

Address: ____

City: _________________________________ State/Zip: _________________________________

Please Circle Best Contact Number:

Home Phone: _______________________ Cell Phone: ________________________

Work Phone: _______________________ Date of Birth: ________________________

SS #:_________________________________ Marital Status: **S / M / D / W**

Email:____

Emergency Contact:________________________________Phone No. ___________________________

May we send correspondence to your home address: **Yes / No**

Would you like to be added to our Email Newsletter and Special Offers List: **Yes / No**

How did you hear about us: ____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age:

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles:

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

Medications:

List all medications you are currently using or taking, including Vitamins, Herbs, Weight loss Products, Retin A, Glycolic Acid and Accutane: ____

____

Are you currently taking aspirin, Plavix, Coumadin, Blood-thinners, Ibuprofen or any anti-inflammatory drugs? **Yes / No** If so, what products? ____

Skin Type – when exposed to the sun **<u>without protection</u>** for about 1 hour you:

____ Always burn, never tan Type I
____ Almost always burn, sometimes tan Type II
____ Sometimes burn, sometimes tan Type III
____ Always tan (American Indian) Type IV
____ Are Hispanic, Asian, Mediterranean, Middle Eastern Type V
____ Are Black (African descent) Type VI

Allergies:

List any **drug, makeup, skin or food allergies** (including drugs taken by mouth, soaps or cleansing creams):

____

Are you allergic to **lidocaine** (numbing medication)? __________
Are you allergic to **nickel or nickel products**? __________
Are you allergic to **leather, cow (bovine), horse or sheep products**? __________

Surgical History:

Have you had any surgeries on your body? **Yes / No** If so, what and when? ________________________

____

List any Accidents or Injuries: ____

Social History:

Use of Alcohol: Never ____ Rarely ____ Moderate _____ Daily _____

Use of Tobacco: Never_____ Quit_____(Year_____) Current Packs/day _____

Are you now or have you been under the care of a physician within the last two years? **Yes / No** If *yes, please provide Physician's name and phone number* ______________________________

____

Do you get pigment or brown spots from an injury, insect bite, pimple or cut? **Yes / No**

Are you taking any medications that make you sensitive to sunlight? **Yes / No** If so, what products?
____

Are you using any eye drops or other ocular medications? **Yes / No** If so, what products? ____________

____

Do you use chemical tanning solutions? **Yes / No** If so, what products? ___________________________

Are you planning a holiday in the sun? **Yes / No** If so, when? ___________________________________

Have you ever had any Photo-Rejuvenation sessions? **Yes / No** If so, where and when? _____________

____

Have you recently undergone a Microdermabrasion or chemical peel? **Yes / No** If so, where and when?

____

When were you last exposed to the sun, including tanning booths? _______________________________

Do you have or have you had any of the following conditions? (Answer Yes or No):

____ Abnormal Heart Condition
____ Cold Sores/Fever Blisters
____ Herpes Simplex
____ Hemophilia
____ High or Low Blood Pressure
____ Prolonged Bleeding Condition
____ Circulatory Problems
____ Epilepsy
____ Diabetes
____ Fainting Spells/Dizziness
____ Cataracts
____ Glaucoma
____ Rosacea
____ Mitral Valve Prolapse
____ "Dry Eye"
____ Corneal Abrasions
____ Eye Surgery or Injury
____ Keloid formation or scars
____ Endocrine Disorders
____ Pacemaker or Internal Defibrillator

____Blepharoplasty (eyelid surgery)
____Visual Disturbances
____Cancer of any kind
____Tumors/Growths/Cysts
____Chemotherapy/Radiation
____Asthma
____Accutane Therapy
____Hormone Replacement Therapy
____Implanted Devices
____Sickle Cell Disease or Trait
____Are you Pregnant or breast feeding
____Pregnancy/Hormone related spots
____Hepatitis
____Kidney Problems
____Do you wear contact lenses?
____Ever had "collagen" injections (e.g. Zyplast or Cosmoplast)
____HIV
____Skin Disorders
____Polycystic Ovarian Disease
____DVT (Deep Vein Thrombosis)

When was your last eye exam?_____/____/____
When was your last Menstrual Period?_____/____/____

Skin Care:

Which of the following best describes your skin? Circle all that apply:

Normal / Dry / Oily / Combination / Acne Prone / Melasma / Rosacea / Eczema / Psoriasis

What skin care product line are you currently using? ____

List skin care products you have had a reaction to: ____

Have you ever had any of the following Spa Treatments? (Please circle below):

Facial / Massage / Microdermabrasion / Chemical Peel / Laser

If so, when/what type? ____

Please use this space to discuss your aesthetic concerns or any additional information you would like us to know: ____

____

Patient Signature:____ **Date:** ________________

Reviewed By: ____

Score	Questions	0	1	2	3	4
	What is the color of your eyes?	Light Blue, Grey, Green	Blue, Grey, or Green	Blue	Dark Brown	Brownish Black
	What is the natural color of your hair?	Sandy red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black
	What is the color of your skin? (Unexposed areas)	Reddish	Very Pale	Pale with a beige tint	Light Brown	Dark Brown
	Do you have freckles in sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful, redness, blistering, peeling	Blistering, followed by peeling	Burns sometimes, followed by peeling	Rarely burns	Never have burned
	To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total Score:	Score	Fitzpatrick Skin Type:
	I	0-7
	II	8-16
Skin Type:	III	17-25
	IV	25-30
	V-VI	Over 30

Patient Signature:____ **Date:** __________________

Dr. Richard Pierzchajlo
1489 Kennedy Road
Tifton, Georgia 31794

(229) 238-2007
Solemedspa.com
info@solemedspa.com

Cold Sore Prophylaxis Instructions

Based upon your history of having had cold sores/fever blisters (no matter how long ago you had them) you need to take an antiviral medication (such as Valtrex) to prevent an outbreak before you get certain treatments that may incite a sore to occur around the mouth and lips.

You must take the medications as directed before each and every treatment you have. If there is an oversight in this regard, this is not a problem. Just let us know and we can reschedule your appointment for another time. It is better to do this than risk creating a cold sore that can last for up to a month and would postpone any additional treatments you may have scheduled for an even longer period.

Please take the medication as instructed below:

Valtrex (valacyclovir):

Take one 1 g caplet twice a day for 5 days.
Take the first dose on the day before (or the day of) each treatment.
Continue the medication for two days around each treatment.

Your health insurance may help cover the cost of this medication. Please check with your pharmacy.

If you have any questions or concerns, please call us anytime,

_____ I have **never** had cold sores/fever blisters. _____I have **had** cold sores/fever blisters.

Patient Signature **Date** **Witness Signature** **Date**

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Photograph Consent

I consent to the taking of photographs as a part of my confidential medical records and to the usage of these photographs for documentation, research and medical teaching.

Patient Name: ____

Patient Signature: ____________________________________

Date: ____

I also grant permission for Dr. Richard Pierzchajlo the unlimited use of my photographs or videos not limited to one date of service for the following types of media. I further acknowledge that there were no promises of compensation for use of photos or videos

Yes / No

☐ ☐...Print (Newspaper, Ads, and Events) and commercial broadcasts
☐ ☐...Visual (for other Patients)
☐ ☐...Facebook and other social media
☐ ☐...Internet (Website) and any marketing materials
☐ ☐...I wish to have my photos uploaded, emailed or printed for my personal use.

This consent may be revoked at any time with written request by patient.
By signing below, I confirm that I understand this consent form.

Initials ________

Email: ____

Patient Signature:______________________________________

Date:_______/_________/__20________

mm dd yyyy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this Family PrimeCare/Solé Med Spa's Notice of Privacy Practices.

____

Please print your name here

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

____

____

____

____ ____________________

Employee signature *Date*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on March 26, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Nadine Cook. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 for each page and the staff time charged will be $25.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may

disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 for each page and the staff time charged will be $25.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: **Family PrimeCare, LLC/Solé Medical Spa** Privacy Officer: **Melissa Pierzchajlo**

Telephone: **(229)391-9931** Fax: **(229)391-9961**

Email: **mapierzchajlo@gmail.com**

Address: **1489 Kennedy Road, Tifton, Georgia 31794**