



MEDICAL HISTORY

Full Name: _____

First

Last

M.I.

Nickname _____ Date of Birth: ____/____/____ Age: _____ Sex: M F
(MM / DD / YYYY)

Home Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Email: _____ Phone (____) _____

Emergency Contact: _____ Phone: (____) _____

How did you find us? Google Facebook Drive-by MINTbody Website Other/Friend _____

Primary Care Physician (PCP) _____ Date of Last PCP Visit _____

Medical History (Circle all that apply):

- | | | | |
|----------------------|----------------------------|---------------------------|-------------------------|
| Acne | Cold Sores/Herpes | Heart Disease | Melanoma or Skin Cancer |
| Arthritis | Dental Work | Hepatitis B or C | Neuropathy |
| Auto Immune Disorder | Diabetes | High / Low Blood Pressure | Permanent Makeup |
| Bleeding Disorders | Eczema / Psoriasis | Hormone Replacement | Rosacea |
| Cancer | Hearing Aid/Contact Lenses | Keloid Scarring | Seizures |

Other Conditions: _____

Allergies: _____

Are you sensitive/allergic to any oral/topical medications? **Specifically: Papaya, Almond, Pumpkin, Latex, Sulfa, Benzoyl Peroxide, Lidocaine, Tetracaine, or any other anesthesia (local, topical, general)?**

Major Illnesses: _____

Surgical History (including plastic surgery and wisdom teeth removal): _____

Esthetic Treatment and Procedure History: _____

Do you or your family have a history of: diabetes, allergies, atypical moles, vitiligo, keloid scarring, melanoma, or skin cancer? If yes, please explain: _____

Medications/ Supplements Used in Last 6 Months: _____

Please answer yes/no to the following questions:

- | | | |
|---|-----|----|
| 1. Are you currently being treated for any medical condition? | Yes | No |
| If so, please explain: _____ | | |
| 2. Are you currently pregnant, trying to become pregnant, or nursing? | Yes | No |
| 3. Do you have any skin diseases or infections? | Yes | No |
| If so, please explain: _____ | | |
| 4. Have you used Accutane in the past 12 months? | Yes | No |
| 5. Are you currently using Retinoids? | Yes | No |
| 6. Are you currently on Blood Thinners and/or Steroids? | Yes | No |

ACKNOWLEDGEMENT:

I, _____ (print name) confirm that the answers I have provided are true and I have not withheld any information that may be relevant to my treatment. I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian.

Patient/Guardian Signature _____ Date _____



PRIVACY & OFFICE POLICIES

Thank you for choosing MINTbody Med Spa & Wellness (Mintbody) for your medical and aesthetic needs. We would like to keep you informed of the office policies. Please read each of the following sections carefully and initial:

Privacy: We collect personal health information about you directly from you which may include your name, date of birth, address, email, phone numbers, health history, and confidential photography records of your visits. We may use and disclose your personal health information to the appropriate providers to:

- o Receive payment for your treatment and care (Credit Card / Care information),
- o Plan, administer and manage our internal operations,
- o Conduct quality improvement & keeping you informed (i.e satisfaction surveys and specials advertising)
- o Comply with legal and regulatory requirements and fulfill other purposes permitted or required by law,

We take steps to protect your personal information from theft, loss and unauthorized access, copying, modification, disclosure and disposal. We conduct audits and complete investigations to monitor and manage our privacy compliance. We take steps to ensure that everyone who performs services for us protects your privacy and only uses your personal health information for the purposes you have consented to.

Refund: ALL SALES ARE FINAL. Before a service is performed please consider all the required protocols and possible side effects. We are committed to client satisfaction and are available to answer any questions or concerns you may have in regards to the services we offer before purchase. Some products sold by our practice are medical grade if so are subjected to state and federal laws. These laws do not permit us to restock sold items and accept returned prescription products/medications for refund.

Insurance: Mintbody does NOT participate with or submit billing for any insurance companies. We can provide you with a copy of your receipt upon request should you seek reimbursement from your insurance company.

Payment: COMPLETE PAYMENT IS EXPECTED AT THE TIME OF SERVICE; some services require a non-refundable deposit prior. Accepted forms of payments: cash/debit, major credit cards, Care Credit, and HSA/FSA

Appointments: Missed appointments represent a cost to us, to you and to other clients who could have been seen in the time set aside for you. We require a 24 hour notice for canceling or rescheduling of any appointment. There is a charge of \$25.00 for missed or late cancelled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

Package/Series Agreement: All Body Contouring & Sculpting, Laser Hair, Photofacial, Resurfacing, Facials, Peels, Massages, Weigh Loss, Body Wraps & Scrubs and any other custom packages are all NON-REFUNDABLE and cannot be substituted for any other packages. All series expire after 365 days from date of purchase. It is the responsibility of the patient to schedule and plan accordingly to use all the sessions within that time. Expired sessions will NOT be replaced or refunded.

Prescription Medication: Some of the medications prescribed by our nurse practitioner is deemed as controlled substances and must be monitored regularly. All patients are required to have a consultation with our nurse practitioner and must be monitored on a monthly basis in order to receive any prescription refills.

Lab Work: I understand Bloodwork testing is mandatory for all weight loss and hormone programs and that I will not be prescribed any medication without the required tests. Some testing may need to be repeated monthly.

Services: Mintbody has the right to refuse treatment and/or dismiss a client from any service at any time. I also understand that I may not be a candidate for certain services and it is at the full discretion of the medical provider to determine whether I am a candidate for any service provided.

Media: We like to share success stories to educate other individuals on treatments performed. I give Mintbody permission to publish my photos/video segments internally, on their website and social media for the primary purpose of referencing services and treatments performed by their providers.

I have read, understand and agree to the policies set forth by MINTbody Med Spa & Wellness. I understand that refusal to sign this consent may result in Mintbody refusing to provide services to me.

Patient or Guardian Signature: _____ Date: _____

Patient's Name (Please Print): _____

At your request, a copy of these policies can be provided for you