TRUECARE

COSMETIC SURGERY & MED SPA

Patient Information & Medical History

PERSONAL INFORMATION

Today's Date: _____

Last Name: _____

First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ ☐ M / ☐ F

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ **Cell Phone** :_(_____) _____

E-Mail Address: _____(We do not share or sell your information)

Occupation: _____

Emergency Contact Information

Name: _____

Phone: (_____) _____

Relationship to you: _____

Legal Guardian Information (IF PATIENT UNDER 18 YEARS OF AGE)

Name: _____

Phone: (_____) _____

Relationship to you: _____

How were you referred to us? (Please check one):

☐ Friend: Name: _____ May we contact them Y N

☐ Internet Website: ☐Google ☐Yahoo ☐CitySearch

☐ Walking By

☐ Other (Please Specify): _____

TREATMENT REQUESTED

☐	Botox	☐	PRP
☐	Dermal Fillers	☐	Micro Needling
	*Voluma/Juvederm/Belotero	☐	Non-Surgical Lift
☐	Microdermabrasion	☐	Surgery
☐	Chemical Peels	☐	Liposuction
☐	Cellulite Reduction	☐	Hyperhidrosis
☐	Acne Scars	☐	Spider Vein Therapy
☐	Pigmentation/Brown Spots/Sun Damage	☐	Laser Hair Reduction
☐	Wrinkle Reduction	☐	Laser Skin Rejuvenation
☐	Fat Reduction	☐	Other: _____

May we contact you for promotions via email, voice mail, or text: Y N

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MEDICAL HISTORY

Are you currently under the care of a physician? ☐YES ☐ NO

If yes, for what:_____

_____

Are you currently under the care of a dermatologist? ☐YES ☐ NO

If yes, for what:_____

_____

Do you have a history of erythema Ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat? ☐YES ☐ NO

Tobacco: Y N Amount: _____ **Coffee/Tea/Soda: Y N Amount: _____**
Alcohol: Y N Amount: _____ **Daily Exercise: Y N Amount: _____**

Medications, Vitamins,Herbs,or Onitments:_____

_____

Regular Aspirin Use: Y N **Ibuprofen (Motrin, Advil): Y N**
Medication Allergy: Y N **Name & Reaction**_____
Latex Allergy Y N **Source & Reaction**_____
Tape Allergy: Y N **Type & Reaction:** _____

Abnormal Bleeding: Y N	**Cancer: Y N**	**Hepatitis: Y N**	**Reflux/Heartburn: Y N**
Diabetes: Y N	**Anemia: Y N**	**Fainting Spells: Y N**	**High Blood Pressure: Y N**
Asthma: Y N	**Seizures: Y N**	**Cardiac/Disease: Y N**	**Mitral Valve Prolapse: Y N**
Blood Clots: Y N	**Sleep Apnea: Y N**	**HIV/Aids: Y N**	**Blood Transfusion: Y N**
Complications From Anesthesia Problems, You or Family Member: Y N			**Cold Sores: Y N**

Please describe all **"YES"** responses: _____

_____

Have you had any recent tanning, use of self-tanning lotions, or sun exposure that changed the color of your skin?
☐YES ☐ NO

Do you form thick or raised scars? ☐YES ☐ NO

Do you have Hyper Pigmentation (darkening of the skin) or Hypo Pigmentation (lightening of the skin) or marks after physical trauma? ☐YES ☐ NO If yes, please describe: _____

_____

FOR ALL PATIENTS:

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 technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Print Name: _____Signature: _____Date:

TRUECARE

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GOOD FAITH EXAM

Client Name: _____ Date: _____

I understand that TRUECARE and the providers are providing services to me related specifically and only to the cosmetic improvement of my appearance which may include the use of laser therapy by a licensed professional. TRUECARE is a medical aesthetics establishment and not a dermatology or plastic surgery practice. The examination does not represent a complete history and physical or any other area of medical practice

Client Signature: _____ Date: _____

PROVIDER USE ONLY

Chief Complaint: _____

Relative past medical history:

_____

_____

- € Intake form reviewed
- € Client is not taking contraindicated medications
- € Client is not pregnant or breastfeeding. LMP:_____
- € Client has not experienced prolonged exposure to the sun within the last two weeks without use of sun block
- € Client has not been on Accutane within the previous 6 months

Limited Physical Examination:

_____

_____

Impression:

- € Unwanted hair: _____
- € Pigmented lesion: _____
- € Vascular lesion: _____
- € Facial Rhytides: _____
- € Other:_____

Plan:

- € Client is an appropriate candidate for
  - € Laser 360
  - € B12
  - € Acne
  - € Juvederm
  - € Chemical Peel
  - € Facial
  - € Botox
  - € Latisse
  - € Dermaplanning
  - € LHR
  - € Skin Tight
  - € Ultherapy
  - € Lipo
  - € DermaPen
  - € IPL/AFT

Client is not a candidate for _____treatments.

Reason_____

_____

Recommendation_____

_____

Provider Signature_____Date_____

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TRUECARE Cosmetic Surgery & Med Spa

CANCELLATION POLICY

At TRUECARE Cosmetic Surgery & Med Spa we strive to give you a great experience and the best services possible. In order to achieve this, we must strive to do it in an efficient timely manner. For this reason we require at least 24 hours notice when you cannot keep an appointment. We would hate to see an appointment to go unused when another Patient may have benefited from that appointment time.

It is the policy of TRUECARE Cosmetic Surgery & Med Spa that if a Patient cancels a scheduled appointment less than 24 hours before their appointment time, or a Patient does not show up for a scheduled appointment, the Patient will be charged fee of $50.00, appointments in length of sixty minutes or longer are subject to A fee of $75.00

_____ (Initial)

ACKNOWLEDGMENT:

By signing below, I acknowledge TRUECARE Cosmetic Surgery & Med Spa's no show/cancellation policy. I understand that if I fail to comply with the no show/cancellation policy, I will be charged a fee of $50.00, appointments in length of sixty minutes or longer are subject to a fee of $75.00.

I understand that if I decline to pay the fee, that a treatment will be deducted from my treatment package.

_____ (Initial)

I understand all sales & deposits are final & non-refundable.

_____ (Initial)

Patient Signature _____Print Name_____ Date _____

TRUECARE

COSMETIC SURGERY & MED SPA

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.

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health 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.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including, but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, training of medical students, licensing, contacting, or arranging for other business activities. We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders

We may contact you to provide appointment reminders.

Treatment Information

We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Department of Health and Human Services

We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation of determination of our compliance with relevant laws.

Family and Friends

Unless you object, we may disclose your medical information to family members, other relatives, or close personal friends when the medical information is directly relevant to that person's involvement with your care.

Notification

Unless you object, we may use or disclose your medical information to notify a family member, a personal representative, or another person responsible for your care of your location, general condition, or death.

Disaster Relief

We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose Of coordinating with that entity to assist in disaster relief efforts.

Health Oversight Activities

We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure, or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect

We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings

We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement

We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Coroners, Medical Examiners, and Funeral Directors

We may disclose your medical information to a coroner, medical examiner, or a funeral director.

Organ Donation If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Research

We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.

Public Safety

We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Worker's Compensation

We may disclose your medical information as authorized by laws relating to worker's compensation or similar programs.

Business Associates

We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

AUTHORIZATIONS:

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Babak Farzaneh, M.D.
Truecare Cosmetic Surgery
4511 Chino Hills Parkway Suite A
Chino Hills, CA 91709
909-590-2299

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

You have the following rights with respect to your medical information:

You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.

You have the right to receive communications from us in a confidential manner.

Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

You have the right to receive an accounting of the of the disclosures of your medical information made by our practice during the last six years (or following August 1, 2007) except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.

You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact: Babak Farzaneh, M.D.

Truecare Cosmetic Surgery
4511 Chino Hills Parkway Suite A
Chino Hills, CA 91709
909-590-2299

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

US Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

THIS NOTICE IS EFFECTIVE AS OF March 5th, 2010.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at our office and will make paper copies of the revised Notice of Privacy Practices available upon request.

TRUECARE

COSMETIC SURGERY & MED SPA

Acknowledgment of Receipt of Privacy Notice

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____

Print Name of Patient or Legal Representative

_____

Signature of Patient (or Legal Representative)

_____

Date

_____

Signature of Employee

_____

Title of Employee / Date