Vitality Medispa and Medical Clinic

New Patient Information

Name: _____ Birth Date: ____ / ____ / ____ Age: _____

Address: _____ Sex: M / F

City: _____ State: _____ Zip Code: _____

Home: (___) _____ Cell: (___) _____

E-mail: _____

Emergency Contact: _____ Telephone: (____) _____

Do we have permission to leave a detailed message on your phone if needed? ☐ Yes ☐ No

How did you hear about Vitality MediSpa & Medical Clinic?

☐ Google or web ☐ CitySearch ☐ Yelp ☐ Walked by/local ☐ Banner Outside ☐ Radio Ad
☐ Current customer: _____ ☐ Employee of Vitality: _____
☐ Physician Referral: _____ ☐ Gift Certificate ☐ Other: _____

GENERAL INFORMATION:

Who may we thank for referring you? _____
Occupation: _____ How much water do you consume daily_____
List all medication allergies

_____

SKIN TYPE/BACKGROUND: Please circle the skin type that describes you the closest:

Skin Type 1 - Very fair, always burn never tans
Skin Type 2 - Fair, Always burns, sometimes tans with difficulty
Skin Type 3 - Fair to light olive, sometimes burns mildly, tans slowly
Skin Type 4 - Olive to light brown, Rarely burns, tans easily
Skin Type 5 - Dark Brown, Very Rarely burns, always tans
Skin Type 6 - Black, never burn, always tans

MEDICATION: check all that you are currently taking or have taken within the past year
□ ANTIVIRAL MEDICATIONS □ RETINOIDS □ ACCUTANE □ STEROIDS □ ANTIBIOTICS
□ ASPIRIN/BLOOD THINNERS □ BIRTH CONTROL/HORMONE REPLACEMENT
□ CHLOROQUIN/HYDROXYCHLOROQUIN

□ IMMUNOSUPPRESSANT □ HYDROQUINONE □ ANTI-DEPRESSANTS

List any additional medications or herbal supplements you are currently taking or have taken in the last year:
_____

MEDICAL HISTORY AND/OR ILLNESSES:
□ DIABETES □ COLD SORES / HERPES SIMPLEX VIRUS □ VASCULAR DISEASE
□ MELANOMA □ POLYCYSTIC OVARIAN SYNDROME □ VITILIGO □ THYROID HORMONE DEFICIENCY □ HIGH BLOOD PRESSURE □ METAL IMPLANTS □ EPILEPSY □ CANCER
□ RADIATION/CHEMOTHERAPY □ HEART PROBLEMS □ AUTOIMMUNE □ PREGNANT OR NURSING □ HEPATITIS □ KELOID/SCARRING □ SEIZURES □ STROKE
□ OTHER _____

AESTHETIC/WELLNESS HISTORY: Please check off any treatments you have had/tried in the past:
□ BOTOX □ DERMAL FILLERS (RESTYLANE/JUVEDERM ETC) □ PEELS □ LASER
□ ELECTROLYSIS □ FACELIFT/LID SURGERY □ HORMONE REPLACEMENT □ ACUPUNCTURE
□ LIPOSUCTION □ FACIALS □ WAXING

IMPORTANT INFORMATION

Please read the following carefully, Initial and Sign after Reading

The following will assist in clarifying Vitality Medispa & Medical Clinic financial policies

Payment Policy: Appointments must be paid in full at the time of service. We accept Visa, Mastercard, Amex, Discover, cash or check. There will be a $50 fee for any returned checks. We offer financing through Care Credit and also offer payment plans in house.

Initial _____

Refund Policy: Since our package services are discounted significantly, no refunds are given for packages partially used unless the treatment cannot be completed for medical reasons. We are happy to provide credit and/or exchange services within the same treatment category (ie if you purchase an IPL laser package and wanted to change/exchange them for an alternative type of laser treatment).

Initial _____

Appointments and Cancellation Policy: We respect the value of your time and ask the same of you. Therefore, we request the courtesy of a **24 hour** advanced notice for rescheduling or canceling your appointment. All appointments have been designed and scheduled to allow the appropriate time for the full enjoyment and proper and careful performance of your service or consultation**. Late arrival (10 or more minutes) may limit our ability to offer the fullest experience possible or may not allow us to perform your service that day. Please understand this respects the client that has an appointment immediately following your scheduled appointment.**

Cancellations for all spa and medical appointments require 24 hours notice. Late cancellations made less than 24 hours or failure to honor appointments will result in a **$125 charge** and donated to Vitality's charity of choice.

Initial _ _____

Records: We keep a confidential record of your health care at Vitality. Our patients are given their patient records upon completion of their doctors visit if requested and if a medical records release authorization form is signed. Please allow up to 10 days to process any record requests and a **$25.00** records administration fee may be assessed. We do not disclose your record unless you direct us to do so or unless the law authorizes such.

Initial _____

Insurance and Medicare: Vitality does not bill insurance companies. Dr. Meraglia is not a preferred provider with any insurance carrier. You may submit a copy of your receipt to your own insurance for reimbursement. We are not a Medicare provider. Medicare will not reimburse you for services at Vitality and you should not seek reimbursement from Medicare for your services here. We will be happy to answer any brief questions you may have about insurance, however we will not provide consultation or complete paperwork from any insurance carriers or their representatives.

Initial _____

By signing below I understand that I will have asked Dr. Tami Meraglia of Vitality Medispa & Medical Clinic for help and that she will do so to the best of her ability.

I have read and understand fully the above statements.

_____ _____ ____

Printed Name ***Signature*** ***Date***

_____ _____ _____

Printed Name Signature (by guardian if under 18) Date

Vitality Medispa & Medical Clinic

Tami S Meraglia, M. D

Notice of Privacy Policy

Understanding Your Health Information:

A record of your visit is made each time you come to our facility. This record may contain personal, identifying information about you, your health, and treatments here at Vitality. This information is needed for the following purposes:

- A record for planning your care and treatment
- Legal documentation describing the care you receive
- To help technicians/physicians make decisions about your care

Your Health Information Rights:

Your records are confidential and you have the right to:

- Request that we limit certain uses and releases of your information
- Request that you get a copy and are allowed to see your records
- Request that any or all communications of your health information be made by different means or to a different location

Our Responsibilities:

We are required to:

- Protect the privacy of your information
- Respect reasonable requests to communicate health information by different means or to different locations

Acknowledgement of Receipt:

By signing this form, I acknowledge that I have received a copy of Vitality Medispa & Medical Clinic "Notice of Privacy" practices:

I authorize disclosure of my protected health information to the person(s) indicated below:

□ Spouse only _____
Print name

□ My immediate family _____
Print name (s)

□ Other _____
Print name (s)

_____ _____
Patient Signature Date

Vitality Medispa & Medical Clinic

Tami S Meraglia, M. D

Photograph Usage Consent Form

Option A

I consent to the taking of photographs prior to, during, and after my cosmetic procedure.

I understand that regardless of how my photos are used, my name and/or other personal information about me will NOT be used in any material or ever be published.

I give Vitality the right to use, reproduce, and distribute my photograph for marketing purposes so long as I am made aware of where the images will be used an how.

Y □ N□ _____
Initial

I allow Vitality to use my photos for medical seminars and/or for educational and research purposes. Y □ N□ _____
Initial

I may revoke this authorization at anytime by providing a notice in writing to Vitality Medispa & Medical Clinic.

_____ _____
Patient Signature Date

Option B

I authorize the taking of my photographs solely for documentation of my medical chart with Vitality Medispa and Wellness Center.

_____ _____
Patient Signature Date

Self Assessment

One of our main goals at Vitality is to LISTEN to you and truly understand why it is you are coming to us for care. Please help us understand your needs by completing this self assessment of the ‘problems’ or ‘concerns’ you may have.

√	**Check any that apply to you:**
	Sun damage/Brown spots
	Lines & Wrinkles
	Loss of Volume/Tired looking
	Sagging skin
	Under eye circles/wrinkles
	Veins on face and/or legs
	Dull, lifeless skin
	Acne
	Rosacea
	Melasma
	Broken Capillaries
	Scarring
	Tired of shaving/razor bumps
	Thin Lips
	Cellulite
	Trouble sleeping
	Weight Issues
	Fatigue
	Hot Flashes/ Mood swings
	Nutritional Concerns/Digestion problems
	Fertility
	Tired of putting make-up on

Draw on or mark any areas of your face and/or body that concern you: