THE LASER COSMETIC CENTER
DERMATOLOGY ASSOCIATES

Date:_____

NEW CLIENT FORM

Name:

Address: City: State: Zip:

Email: May we email promotions and/or reminders to you? Y N

Phone Number: ❍ Home ❍ Cell
May we text appt reminders to you? Y N
If "yes", please circle your cell phone carrier: Verizon AT&T Alltell Cellular One

Occupation: Employer:

Date of Birth: Age: Children: 0 1 2 3 4 5+

What medications are you currently taking?

Please list any allergies:

Do you get cold sores, fever blisters, or herpes outbreak? YES NO What medications do you take for it?

FITZPATRICK CLASSIFICATION SYSTEM: Please select the skin type that seems to best describe your skin

SKIN TYPE	SKIN COLOR	CHARACTERISTICS
❍ I	White	Always burns, never tans
❍ II	White	Usually burns, tans less than average
❍ III	White	Sometimes mild burns, tans about average
❍ IV	Brown	Rarely burns, tans more than average
❍ V	Brown	Rarely burns, tans profusely
❍ VI	Black	Never burns, deeply pigmented

What is your ethnicity? (ie: Irish, Native American, etc.) This is important for us to determine appropriate treatment setting:

Skincare Concerns: Please select all that apply

❍ Fine Lines/Wrinkles	❍ Excess Hair	❍ Sagging Skin	❍ Laugh Lines/Fold Around Mouth
❍ Skincare	❍ Age Spots/Freckles	❍ Acne	❍ Broken Capillaries on Face/Body
❍ Large Pores	❍ Rosacea/Redness	❍ Spider Veins	❍ Other:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I certify that the above information is correct to the best of my knowledge.

Patient Signature_____ Printed Name_____ Date_____

THE LASER COSMETIC CENTER
DERMATOLOGY ASSOCIATES

The Laser and Cosmetic Center Policies

Payment in Full
Payment is expected at the time of service. The Laser and Cosmetic Center does not accept insurance for any of the procedures performed. Advance deposit is required in order to secure a time on our schedule for treatment of Coolsculpting and Fraxel. If you are running late, let us know as soon as possible and we will try to accommodate you without disrupting other client appointments (in some cases, we may need to reschedule your appointment).

We have a wide variety of appointment times available and book up to several weeks in advance. Some days and times are more popular than others. We do our best to accommodate your requests for a particular day and time. However, all appointments are on a first come first serve basis.

Cancellation Policy
The Laser and Cosmetic Center has a 24-hour cancellation policy. Should you need to cancel or reschedule an appointment please give us 24 hours-notice so we can make the time available to other clients. Failure to show up for a scheduled appointment will result in forfeiture of prepaid services booked. **Failing to cancel a scheduled appointment is considered a no-show, and may be subject to a charge. Patients with multiple no-shows may be terminated from the practice.**

Return Policy
No refunds are made for products, services, service packages and pre-paid treatments once they are purchased. If for some reason you are not able to use an un-rendered, pre-paid service, you may do a one-time exchange of the unused portion toward other services.

Treatment Expiration
All Service packages and pre-paid treatments must be used within 12 months of date of purchase or they will expire.

Treatment Outcomes
The Laser and Cosmetic Center is committed to serving you in the best way that we can. We will be honest in all our dealings with you. Aesthetics is not an exact science and how you may respond to a given treatment will vary from person to person. It is virtually impossible to predict results and therefore payments made for services are for treatments to be performed – not for a specific result. However, we always strive to achieve the absolute best result that we can for you. Thank you for allowing us to serve you!

Rights Reserved
The Laser and Cosmetic Center will try to communicate policy changes with you in advance wherever possible. However, we do reserve the right to change our policies without notice.

Patient Name:_____ **Date:**_____

Patient Signature:_____

NOTICE OF PRIVACY PRACTICES

)ermatology Associates, PLLP ' Effective Date: April, 2003

'HIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN CCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions about this notice, please contact: Privacy Officer; 'ermatology Associates, PLLP; 175 Commons Loop, Suite 300; Kalispell, MT 59901; Phone: 406-756-7555.

/HO WILL FOLLOW THIS NOTICE : This Notice of Privacy Practices applies to Dermatology Associates, PLLP and describes our practices and that of: 1) ny health care professional authorized to enter information into your chart; 2) All departments and units of the organization covered by this notice; 3) Any iember of a volunteer group we allow to help you; 4) Any organization that we retain to support operation of this practice that has executed an agreement ·garding uses and disclosures of your protected health information.

UR PLEDGE REGARDING MEDICAL INFORMATION: We may share medical information for treatment, payment or operational purposes described in iis notice. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. /e create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. his notice applies to all of protected health information created by any of the organizations listed in this notice. Your doctor may also create information at ie hospital or other medical facility. These facilities may have different policies or notices regarding their use and disclosure of your medical information ·eated by your doctor while at that facility. This notice will tell you about the ways in which we may use and disclose medical information about you. We so describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to: Make sure iat medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information)out you.; and follow terms of the current notice.

OW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose iedical information. For each category of uses or disclosures, we will explain what we mean and try to give some examples. Not every use or disclosure in category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

SES OR DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION OR AN OPPORTUNITY FOR YOU TO OBJECT

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information)out you to doctors, nurses, technicians, medical students, or personnel who are involved in taking care of you. For example, a doctor treating you for a ·oken leg may need to know if you have diabetes because diabetes may slow the healing process. We may share medical information about you in order to)ordinate the different things you need, such as prescriptions, lab work and x-rays that are provided by other healthcare organizations. We may use and .sclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive here may be billed to and payment .ay be collected from you, an insurance company or a third party. For example, we may need to give your health information about surgery you received so)ur health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior)proval or to determine whether your plan will cover the treatment. We may also share information about you and any insurance information with other :althcare providers to assist them in getting payment for a service they have provided you. For example, we can share this information with a laboratory :rvice that evaluates your laboratory specimen.

For Health Care Operations. We may use and disclose medical information about you for operation of the organization listed in this notice. These uses id disclosures are necessary to run our organization and to make sure that all of our patients receive quality care. For example, we may use medical formation to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information)out many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We ay also disclose information to doctors, nurses, technicians, medical students, and other organization personnel for review and learning purposes. We may so combine the medical information we have with medical information from other organizations to compare how we are doing and see where we can make)provements in the care and services we offer. We may use your medical information to send questionnaires to you about your experience so that we can entify ways to improve your satisfaction with the services we provide. We may remove information that identifies you from this set of medical information) others may use it to study healthcare and healthcare delivery without learning who specific patients are. We may also produce limited data sets that are :rtially de-identified and that must be used under restrictive agreements for purposes of research, public health, and other healthcare operations described)ove. We may use or disclose your medical information to other health providers who also have a relationship with you for activities related to evaluating e quality of care, for coordinating your care, evaluating the competence of healthcare providers, conducting training, or for fraud or abuse investigation.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project ay involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All search projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to ilance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the oject will have been approved through this research approval process. However, we may disclose medical information about you to people preparing to nduct a research project; for example, to help them look for patients with specific medical needs, so long as the medical information they review does not ave the organization. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information at reveals who you are, or will be involved in your care.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health/Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your alth and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation. We may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may, release medical information about you as required by military command thorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide nefits for work-related injuries or illnesses.

. Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:) prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems th products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for ntracting or spreading a disease or condition; and to notify the appropriate government authority if we believe a patient has been the victim of abuse, glect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

. Health Oversight Activities. We may disclose medical information authorized by law to a health oversight agency to conduct activities such as audits, vestigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and mpliance with civil rights laws.

12. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someor else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

13. Law Enforcement. We may release medical information if asked to do so by a law enforcement official: In response to a court order, subpoena, warrar summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limite circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct in tl office of Dermatology Associates, PLLP and in emergency circumstances report a crime, location of crime or victims; or identity, description or location of person who committed the crime.

14. Coroners, Medical Examiners, and Funeral Directors. As necessary, we may release medical information to a coroner or medical examiner, for example, to identify a deceased person or determine the cause of death, and may release medical information about patients to funeral directors.

15. National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

16. Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

17. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

USES OR DISCLOSURES WHEN YOU HAVE AN OPPORTUNITY TO OBJECT

1. Facility Directories and Religious Preferences. Unless you object, we may include your name in any facility directory and we may list any religious preference you tell us in a directory provided to clergy.

2. Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your general condition and that you are in the hospital. In addition, we may disclose medical information about you to an entity assisting in a disaste relief effort so that your family can be notified about your condition, status and location.

USES OR DISCLOSURES THAT CAN ONLY BE MADE WITH YOUR AUTHORIZATION: Uses and disclosures of medical information not covered b this notice or laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take bacl any disclosures we have already made with your permission, and that we are required to retain our records of care we have provided to you.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You have the following rights regarding medical information we keep about you:

1. Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, thi includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decision about you, you must submit your request in writing to: Privacy Officer, Dermatology Associates, PLLP; 175 Commons Loop, Suite 300; Kalispell, MT 59901; Phone: 406-756-7555. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances if we judge that disclosing information could be detrimental to you or to another party. You have the right to appeal any such denial.

2. Right to Amend. If you feel medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as your information is kept by the organization. To request an amendment, your request must be made in writing and submitted to: Privacy Officer; Dermatology Associates, PLLP; 175 Commons Loop, Suite 300; Kalispell, MT 59901; 406-756-7555. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: was not created by us, unless the person or entity that created the information is no longer available to make the amendment; is not part of the medical information kept by or for the organization; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

3. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to: Privacy Officer, Dermatology Associates, PLLP; 175 Commons Loop, Suite 300; Kalispell, MT 59901; 406-756-7555. Your request must state a time period that may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. Right to Request Restrictions. You have the right to request a restriction or limitation on medical information we use or disclose about you for treatment payment or health care operations. You also have the right to request a limit on medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. *We are not required to agree with your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to: Privacy Officer; Dermatology Associates, PLLP; 175 Commons Loop, Suite 300; Kalispell, MT 59901. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse. A restriction is not granted until you receive written notice of its approval.

5. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to: Privacy Officer, Dermatology Associates, PLLP; 175 Commons Loop, Suite 300; Kalispell, MT 59901. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Privacy Officer; Dermatology Associates, PLLP; 175 Commons Loop, Suite 300; Kalispell, MT 59901; 406-756-7555.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health anc Human Services. To file a complaint with Dermatology Associates, PLLP. contact: Privacy Officer; Dermatology Associates, PLLP; 175 Commons Loop, Suite 300; Kalispell, MT 59901; 406-756-7555. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at the organization covered by this notice. The notice will contain on the first page, in the top right-hand corner, the effective date.