



## Laser Hair Reduction Consent

In signing this document, I \_\_\_\_\_ give permission to Dr Kim Vernon, Spa in the City Lasers or their designate to perform laser hair removal.

I understand that the goal of this procedure is the gradual **permanent reduction** of my hair. I understand that every individual is unique, and it is very difficult to guarantee a specific number of treatments needed. It is expected that I will require a minimum of six to twelve treatments for the body and six to eight treatments for the face. I understand if my goal is not met within the specified number of treatments, I will be treated at no additional charge for 3 months. (Not valid for coupon holders) \_\_\_\_\_ initials

I agree to call the clinic if I have any difficulty after my treatment. \_\_\_\_\_ initials

I acknowledge that I have not waxed the treated area within the previous six weeks nor have I plucked the hair from the area being treated. **I acknowledge that I have not been sun tanning for the previous TWO weeks.** \_\_\_\_\_ initials

Although uncommon, I understand that complications can occur. It has been explained to me that these complications include: a sunburn feeling, redness, local tenderness and mild swelling, occasionally blistering, very rarely pigmentation changes and scarring. \_\_\_\_\_ initials

I understand that how I take care of my skin after treatment influences my risk of complications. I agree to wash my skin gently twice-daily and apply an antibacterial cream for the first week. **I agree to stay out of the sun or to use sufficient sun block for FOUR weeks following my treatment.** I agree to call the clinic if I develop any markings on my skin after treatment, and I will not pick at them. \_\_\_\_\_ initial

I have not taken Accutane within the last 12 months. \_\_\_\_\_ initials

I am not currently pregnant. \_\_\_\_\_ initials

I am a not allergic to topical anesthetics (topical freezing). \_\_\_\_\_ initials

If I have forgotten to tell the clinic staff of my health problems, medications, allergies, or other important information about me, I will do so now. I will inform the doctor if I become pregnant. \_\_\_\_\_ initials

**Blindness and eye damage** – The laser, without protective eyewear, may cause visual loss including blindness. **It is important to keep these shields on at all times** during the procedure and that I **should keep my eyes closed** in order to protect my eyes from accidental laser exposure

I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment.

I hereby give my permission to undergo laser hair reduction

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Hair Reduction Aftercare

1. Immediately after the treatments, there should be redness and bumps at the treatment area, which may last up to 2 hours or longer. It is normal for the treated area to feel like sunburn for a few hours. You should use a cold compress if needed. If any crusting, apply antibiotic cream. We also recommend aloe vera gel or some other after sunburn treatment such as Desitin. Darker pigmented people may have more discomfort than lighter skin people and may require the aloe vera gel or an antibiotic ointment longer.
2. Makeup may be used after the treatment, unless there is epidermal blistering. It is recommended to use new makeup to reduce the possibility of infection. Just make sure that you have moisturizer on under your makeup. In fact, moisturizer will help the dead hair exfoliate from the follicle, so use moisturizer frequently and freely on the treated area. Any moisturizer without alpha-hydroxy acids will work.
3. Avoid sun exposure to reduce the chance of dark or light spots for 2 months. Use sunscreen 25 or higher at all times throughout the treatment and for 1-2 months.
4. Avoid picking or scratching the treated skin. **DO NOT USE** any other hair removal methods or products on the treated area during the course of your laser treatments, as it will prevent you from achieving your best results.
5. You may shower after the laser treatments, and use soap, deodorant, etc. The treated area may be washed gently with a mild soap. Skin should be patted dry and **NOT** rubbed. You may apply deodorant after 24 hours.
6. **Anywhere from 5-30 days after the treatment, shedding of the hair may occur and this may appear as new hair growth. This is not new hair growth, but dead hair pushing its way out of the follicle. You can help the hair exfoliate by washing or wiping with a washcloth.**
7. Hair re-growth occurs at different rates on different areas of the body. New hair growth will not occur for at least three weeks after treatment.
8. Call **(972) 998-6484** with any questions or concerns you may have after the treatment
9. Remember for your next appointment **NO TAN (FAKE OR REAL) 2 WEEKS PRIOR**



**NEW PATIENT PERSONAL INFORMATION**

*Please complete the following:*

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Age: \_\_\_\_\_ Vernon & Waldrep patient? \_\_\_\_\_

How were you referred? \_\_\_\_\_ Have you had Botox before? \_\_\_\_\_

**For our female clients: Are you pregnant or nursing? SSSSSS Using contraception SSSSSS**

Please list all allergies (including medications, food, latex, cosmetics, lidocaine, sulfa, etc.) \_\_\_\_\_

Please list all medications, including herbal (esp. St John's Wort or Fish Oils) \_\_\_\_\_

List all operations (including plastic/laser procedures), hospitalizations, and any serious illnesses: \_\_\_\_\_

What are your concerns (please circle any of the following): unwanted hair, brown/red spots, wrinkles, lines, sagging skin, acne, blemishes, large pores, age spots, spider veins, scars, other (please list): \_\_\_\_\_

Please check all that apply: \_\_\_insulin dependent diabetes \_\_\_high blood pressure \_\_\_cancer \_\_\_stroke \_\_\_blood clots \_\_\_bleeding problems with cuts or surgery \_\_\_jaundice or hepatitis \_\_\_very dry skin \_\_\_thyroid disease \_\_\_active skin disease or lesions \_\_\_dizziness, palpitations or fainting spells \_\_\_cold sores or fever blisters \_\_\_psychiatric disorder \_\_\_hormone imbalance \_\_\_herpes \_\_\_HIV/Aids \_\_\_scars/Keloids \_\_\_active infection \_\_\_vitiligo, scleroderma, lupus, hives \_\_\_unwanted tattoos or permanent makeup \_\_\_other

Please elaborate on checked items: \_\_\_\_\_

Are you currently under the care of a physician? \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

**SKIP TO SIGNATURE IF NOT HAVING LASER**

**PLEASE COMPLETE THE FOLLOWING IF HAVING LASER TREATMENTS**

Which of the following best describes your skin type after 1 hour of unprotected sun exposure? (please circle one skin type #)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

Do you have a history of erythema (Abigne) which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irradiation? \_\_\_\_\_

Have you ever used Accutane, when? \_\_\_\_\_

What topical medications or creams are you currently using? Retin-A, Renova, Rentinol? (others please list) \_\_\_\_\_

Have you used any of the following hair removal methods in the past 6 weeks? \_\_\_ shaving \_\_\_ waxing \_\_\_ electrolysis \_\_\_ tweezing \_\_\_ threading \_\_\_ plucking \_\_\_ depilatories

Have you had any recent tanning or tanning products that changed the color of your skin? \_\_\_\_\_

Do you form thick or raised scars from cuts, surgeries or burns? \_\_\_\_\_

Check any of the following medications you have taken in the last 6 months (as they may increase hair growth or may be contraindications for laser treatments): \_\_\_ birth control pills \_\_\_ androgens (Rogaine) \_\_\_ Penicillin \_\_\_ cyclosporins \_\_\_ Minoxidil \_\_\_ steroids \_\_\_ Haldol \_\_\_ Phenytoin \_\_\_ thyroid medications \_\_\_ St John's Wort \_\_\_ Accutane \_\_\_ Tetracycline

**SIGNATURE**

\_\_\_\_\_  
\_\_\_\_\_

***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, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***I have (circle one) reviewed the medical history or reviewed the medical history and conferred with the patient. I believe there are no contraindications to the planned aesthetic procedure.***

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SPA IN THE CITY

## Notice of Privacy Practices

Effective Date: August 1, 2011

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.**

Protecting your privacy and maintaining the security of your protected health information is one of the most important responsibilities of this office.

If you have any questions about this notice, please contact our **Privacy Officer**.

### **Our Obligations**

We are required by law to:

- Maintain the privacy of protected health information, hereinafter designated "PHI".
- Give you this notice of our legal duties and privacy practices regarding your PHI.
- Follow the terms of our notice that is currently in effect.

### **How We May Use and Disclose Health Information**

Except for the following, we will use and disclose health information only with your written permission:

- Treatment – We may use and disclose PHI for your treatment and to provide you with treatment-related services. For example, we may disclose PHI to doctors, nurses, technicians, pharmacists, including personnel outside our office who are involved in your care and need to provide you with care.
- Payment - We may use and disclose PHI so that we or others may bill and receive payment from you, from an insurance company, or a third party for the treatment and services you received.
- Operations – We may use and disclose PHI for operational purposes. These uses and disclosures are necessary to make sure that all of our clients receive quality care, and to operate and manage our office. For example, your PHI may be shared with quality improvement personnel to evaluate the performance of our staff.
- Appointment Reminders - We may use and disclose PHI to contact you and remind you of your appointment with us.
- Individuals Involved in Your Care or Payment for Your Care - We may use and disclose PHI with a person involved in your care such as your family or a close friend.
- Research - We may use your PHI for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI has approved the research.

### **Special Situations**

- As Required by Law - We may disclose PHI when required to do so by international, federal, state, or local law.
- To Avert a Serious Threat to Health or Safety - We may disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**SPA IN THE CITY**  
**Notice of Privacy Practices**  
**Effective 8/1/2011**

- Business Associates - We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your PHI and are not allowed to disclose any information other than as specified in our contract.
- Lawsuits and Disputes – We may disclose PHI in response to a court order or subpoena only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement - We may release PHI if requested by law enforcement official if the information is in response to a court order, subpoena, warrant, or summons.

### **Your Rights**

You have the following rights regarding your protected health information (“PHI”):

- Right to Inspect and Copy – your medical and billing records. You must make this request in writing.
- Right to Amend – you may ask to amend the information when the information is in our office.
- Right to Accounting of Disclosures – you have the right to request a list of certain disclosures we made of your PHI other than for treatment, payment, operations, or disclosures with your written authorization. You must make this request in writing.
- Right to Request Restrictions – you have the right to request a restriction or limitation on the PHI we disclose for purposes of treatment, payment, operations, or to someone involved in your care or the payment of your care, like a family member or friend. For example, you may request that we not share information about a particular treatment with your spouse. This request must be made in writing. We are not required to agree to your request.
- 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 contact you only by mail or at work. Your request must be in writing and must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- Right to a Paper Copy of This Notice - You may ask us to provide you with a copy of this notice at any time.

### **Changes to This Notice**

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. This notice will contain the effective date on the top of the first page.

### **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Department of Health and Human Services, 200 Independence Ave., SW, Washington, DC 20201. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred. Filing a complaint will not interfere with your health care at this practice.



**SPA IN THE CITY, LLC**

7777 Forest Lane, Bldg D, Suite 570  
Dallas, TX 75230

**Request for Limitations and Restrictions of  
Protected Health Information “PHI”**

Note: We are not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
\_\_\_\_\_

Type of PHI to be restricted or limited: (please check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Home Phone       | <input type="checkbox"/> Home Address          | <input type="checkbox"/> Occupation     |
| <input type="checkbox"/> Name of Employer | <input type="checkbox"/> Visit notes           | <input type="checkbox"/> Cell Phone     |
| <input type="checkbox"/> Patient History  | <input type="checkbox"/> Office Address        | <input type="checkbox"/> Office phone # |
| <input type="checkbox"/> Spouse’s name    | <input type="checkbox"/> Spouse’s office phone | <input type="checkbox"/> Email Address  |
| <input type="checkbox"/> Other: _____     |  |   |

Please explain your restrictions – be specific.  
How would you like use and/or disclosure of your PHI restricted? \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient Date

Original – file in patient chart



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Dallas, TX 75230  
(972) 998-6484

**Receipt of Notice of Privacy Practices  
Written Acknowledgement Form**

**Specifically for SPA IN THE CITY Clients**

I, \_\_\_\_\_, have received a copy

of the privacy practices of SPA IN THE CITY.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date