Consent to undergo Tattoo Removal

In signing this document, I give permission to Dr. Kim Vernon, Spa in the City Lasers or their designate to treat my tattoo with laser.

I understand that the goal of this procedure is improved appearance and eradication of my tattoo. I understand that every individual is unique, and it is very difficult to guarantee a specific result. Thus, I realize that I may require a series of treatments to achieve my objectives. If the tattoo is not eradicated in the specified number of treatments, I will receive additional treatments for a period of 6 months at no additional cost ____________ initial

I agree to call the clinic if I have any difficulty after my treatment. __________ initial

I agree to follow the aftercare protocol which includes washing my treated area twice daily, applying recovery ointment four to six times daily, and inspecting my treated area regularly. **I will keep my treated area out of the sun for a minimum of one month**. I understand that good at-home wound care helps to minimize risk of complications. __________ initial

I understand that although uncommon, complications can occur. It has been explained to me that these complications include: local infection, pigmentation changes, scarring, redness, swelling, tenderness, and temporary worsening of the appearance of my tattoo. I understand that many of these complications are temporary, however I acknowledge that although uncommon the pigmentation changes and scarring can be permanent. _________ initial

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 am pregnant. ___________ initial

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.____________ initial

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 ________________________________hereby give my permission to undergo tattoo removal.

____ ______________________

Signature Date

Tattoo Removal Aftercare

The tattoo removal laser treatment may create a superficial burn wound. Some patients may experience mild bruising and/or swelling. There is immediate whitening of the treated area, which usually lasts for several minutes then disappears. Many clients then develop blisters, crusts, or scabs within 8-72 hours, which may last for 1-2 weeks or more. The treated areas may be pink or pale after the scab separates. Scarring, which can be hypertrophic or even keloid, can occur, but is very rare. Loss of skin pigment in the treated area may occur, and is temporary except in very rare cases. Healing is usually complete within 4 weeks, although this may vary. You may schedule your next treatment in 6-8 weeks.

1. Keep the treated area clean and dry while it is healing. Clean the area ***gently*** with soap and water and then pat the area dry. Apply a thin coating of the prescription cream Biafine. If you choose not to fill the prescription, apply a thin coating of antibiotic ointment (polysporin or triple antibiotic….**not neosporin**) up to 2-3 times a day for 7 days while the area is healing. You should keep the area loosely covered (DO NOT OCCLUDE) with a sterile dressing (non-stick pads and tape) for those 7 days. If you use Biafine, please apply a generous layer of cream 1x daily and cover with a lightly moistened pad and then tape.

2. Blistering is common and is likely to occur 8 hours after your treatment. Do not be alarmed! Blisters heal very well and are part of the normal healing process. Blisters indicate your immune system is healing the area and beginning to remove the ink from your tattoo. It is natural for blisters to pop, and this helps the skin to heal faster in many cases. Continue to put prescription or antibiotic ointment over the blisters once they have popped for **at least 24 hours**.

3. You may apply cool compresses as necessary for 24 hours after the laser treatment to help reduce discomfort and inflammation. (Your treated area may feel warm or even hot) You may take plain Tylenol, but avoid aspirin (it can increase the risk of bruising and/or bleeding.)

4. Do not pick at the scab or allow the skin to become scraped, as this may result in infection and scarring. Shaving should be avoided in the treated area until it is completely healed.

5. Feel free to shower 24 hours after the treatment, but take care to avoid HOT water or high pressure water hitting the treated area. **Baths, hot tubs, swimming pool, or any form of soaking are not recommended until all blistering and scabbing are completely healed, as they may increase the risk of infection.**

6. Exercise is generally safe after treatment, however if excessive sweating occurs it's best to refrain from exercise for 24-48 hours taking into account the other after care instructions provided here.

7. Wear a sun block with an SPF of 25 or higher (Rejuvi sunscreen) over the area for 3 months following the treatment. Do not wear makeup, any cream or medication on or near the treated area unless recommended by our office for 72 hours.

8. Itching is very common due to the dehydrating effect of the laser treatment. Use Aquaphor, vitamin E oil, or hydrocortisone cream to the treatment area AFTER THE INITIAL 7 DAY TREATMENT until skin is normal in appearance.

9. If the area looks/feels infected (honey colored crusting and oozing or spreading redness or excessive heat), or if you experience an unusual discomfort or bleeding CONTACT THE OFFICE IMMEDIATELY. (972)998-6484.

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? ______

[illegible] ave you ever used Accutane [illegible], 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)

___ Home Phone	___ Home Address	___ Occupation
___ Name of Employer	___ Visit notes	___ Cell Phone
___ Patient History	___ Office Address	___ Office phone #
___ Spouse's name	___ Spouse's office phone	___ Email Address

___ 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

7777 Forest Lane, Bldg D, Suite 570
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