



## Laser/Light Assisted Treatment of Vascular/Pigmented Lesions Consent

- ◆ I \_\_\_\_\_ voluntarily request laser/light assisted treatment of lesions that I have proclaimed as “unwanted” in the following areas:  
\_\_\_\_\_.
- ◆ I voluntarily consent and authorize that this laser/light assisted treatment be performed by the staff of this clinic, including physicians, technicians, associates, technical assistants, and other health care providers as deemed necessary by the staff of this clinic. I hereby release Dr Kim Vernon, Spa in the City Lasers and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures. \_\_\_\_\_ initial
- ◆ For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from this clinic, I consent to have this clinic’s staff take before, during, and after treatment close-up photographs of the involved area(s) and the anatomical region surrounding the involved area(s). These photographs shall be used for medical records and shall be treated with the same confidentiality as the remainder of my record at this clinic. \_\_\_\_\_ initial
- ◆ I recognize that this laser/light assisted treatment is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result or cure. There are risks related to the performance of these procedures. I understand and acknowledge that the risks that may occur in connection with this particular procedure may include the following:
  - 1) **Infection** – Albeit rare, skin infection is a possibility any time a skin procedure is performed. I acknowledge and understand that although rare, it is possible for a skin infection to become a blood-borne wide spread infection.
  - 2) **Blood clots in veins and lungs** –Albeit extremely rare, it may be possible to develop a blood clot associated with this treatment that goes (embolizes) to the heart and/or lungs.
  - 3) **Allergic reactions** – Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.
  - 4) **Hemorrhage and bruising** – Bruising in the treated area is possible, especially if, within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that “thin” the blood.

- 5) **Recurrence of the lesion** – I may not experience permanent results even with multiple treatments.
- 6) **Painful or unattractive scarring** – Scarring is a rare complication of laser assisted treatment, but scarring is possible because the skin surface is disrupted by the laser. To minimize the chances of scarring, it is most important that I follow ***all postoperative instructions*** carefully.
- 7) **Discomfort and pain** – Some discomfort will be experienced during and after the laser treatment. I give my permission for the administration of topical and/or local injection of anesthesia when and if deemed appropriate.
- 8) **Pigment changes (skin color)** – During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.
- 9) **Poor healing** – The resultant open wound may require more than the usual one to three weeks to heal.
- 10) **Sun exposure** – Once the surface has healed, it may be pink and sensitive to the sun. Treated areas should be blocked completely, that a **sun block** with an SPF of at least 40, should be used at all times in areas not protected by clothing, whether or not I am in the sun.
- 11) **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 understand and acknowledge that I have been informed, that multiple treatments are often required to cause long-term results and that some patients have no results even with multiple treatments. The usual number of treatments required is two to three, but more treatments may be required. \_\_\_\_\_ initial
- ◆ I have been given an opportunity to ask questions about my condition, alternate forms of anesthesia and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give the informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all of the disclosures referred to herein. 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. \_\_\_\_\_ initial

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## VEIN TREATMENT AFTERCARE

### Post Treatment Instructions:

1. Immediately after the treatments, you should apply an ice pack, as there may be mild swelling. 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 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. After icing please put on compression hose (if treating legs) for a minimum 6 hours/day for 3 days.
2. Makeup may be used after the treatment has quit swelling unless there is epidermal bleeding. It is recommended to use new makeup to reduce the possibility of infection. Keep the area moist. Any moisturizer **without** alpha-hydroxy acids will work.
3. You may shower after the laser treatments in tepid water. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed.
4. You will experience redness and bruising from five to fourteen days at the treatment. Avoid sun exposure to reduce the chance of dark or light spots for 2 months. Use sunscreen SPF 25 or higher at all times throughout the treatment.
5. After the bruising has cleared it takes up to four weeks or longer to observe the maximal effectiveness of that particular treatment.
6. Avoid picking or scratching the treated skin to achieve your best results. Minimal pinpoint crusting can occur so keep the area moist with a Vaseline-type product and avoid picking.
7. Call **(972) 998 6484** with any questions or concerns you may have after the treatment



**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



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