



Consent to Undergo Laser Vein Treatment

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

I understand that the goal of this procedure is improved appearance and eradication of my veins. 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. _____ 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 veins twice daily, applying recovery ointment four to six times daily, and inspecting my veins regularly. **I will keep my veins out of the sun for a minimum of one month.** I understand that good at-home 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 veins. 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 including pregnancy, I will do so now. _____ 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 laser vein treatment.

Signature: _____ Date: _____

Witness: _____ 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
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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