Visage Medical Spa

(Please Print)

PATIENT INFORMATION					
Last name:		First name:		❑ Miss ❑ Mrs. ❑ Ms. ❑Mr	Birth date: / /
Street Address:	P.O. Box:	City:	State:	ZIP Code:	
Home Phone#:	Cell Phone#:		Employer phone #:		
Email Address:	Driver's license#:		S.S. #:		

How did you hear about us?
If you were referred by a friend or relative please provide their name so we may send them a $25.00 credit.

PAST MEDICAL HISTORY

Medical Conditions (check all that apply):
❑ hypertension ❑ heart disease ❑ high cholesterol ❑ diabetes ❑ hypothyroid ❑ hyperthyroid
❑ herpes or cold sores ❑ depression ❑ anxiety ❑ pregnant or breastfeeding ❑ other (please list):

Medications:

Allergies (to medications or latex):

Surgeries:

Alcohol use: Tobacco use (PPD/how long):

Family History (list medical conditions for your parents and/or siblings):

IN CASE OF EMERGENCY

Name of friend or relative (not living at same address):	Relationship to patient:	Home Phone #: Alternate Phone #:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance and that payment is due at the time of service. I understand that a copy of the HIPPA laws will be provided to me upon request. I am open to review these rules and discuss any areas in which I have questions. I have the following rights in regards to my medical record: I can consent to or authorize the use and disclosure of the record with an authorization for release of information form. I may request restrictions on certain uses and disclosures of my record. I may receive confidential communication and receive a copy of my record. I may request an amendment of my record. I may complain about alleged violations to the office and DHHS. I allow Visage Medical Spa to send communications to me via regular mail without being marked "personal or confidential" and to leave voice mail messages at my home or on my cellular phone

-Visage Medical Spa is not contracted with any insurance companies for reimbursement and we do not file claims. Please remember to request an itemized receipt at the time of your check-out if you will be filing with your insurance company, as we can no longer print receipts after the date of your service.

- A service fee starting at the amount of $35.00 will be applied to your account for any/all requests of medical records due to office expense. All correspondence including, faxes, emails, electronic transfers, telephone calls etc. will be considered HIPPA compliant with your signature of this consent. If you are planning on filing a claim with your insurance company, the itemized receipt (if requested by you) will include your diagnosis codes needed by your insurance company in order to process your claim.

-New Office Policy per Providers: Some medications require a base-line blood draw before a prescription is given. There is a fee for this type of blood draw. The fee depends on what lab panels/tests the providers deem necessary, for you individually. Please inquire about fees prior to having your blood drawn. We consider your signature of this form your acknowledgement and understanding of this new office policy. We appreciate your understanding as the providers here at Visage Medical Spa keep their patients best interest in mind.

Please sign below to accept these terms.

X_____ _____ _____
Patient Signature Print Name Date

X_____ _____ _____
Witness Signature Print Name Date