Image Plastic Surgery Sculptors and Day Spa

PERSONAL DATA:

Full name: _____ Name you like to be called: _____

Address: _____ City_____ State: _____ Zip_____

Date of birth: _____ Age: _____ Sex: _____

SS#: _____

Home Phone: _____ Work Phone: _____

Cell phone: _____

E-mail address: _____

Which phone should we contact you on?

_____

May we leave messages on this phone? Y ___ N ___ May we email you? Y ___ N ____

RESPONSIBLE PARTY (for minors under 18):

Name: _____ DOB: _____ Relation to patient: _____

Address: _____ City: _____ State: ____ Zip: _____

Daytime phone: _____ Evening phone: _____ Cell phone: _____

EMERGENCY CONTACT:

Name: _____ Relation to patient:

_____

Work Phone:_____ Home

Phone:_____

EMPLOYER INFORMATION:

Employer: _____ Occupation: _____

Employer's address: _____ Phone number: _____

REFERRAL INFORMATION:

Physician referral: _____ Patient referral: _____ Other: _____

Primary Care Physician_____

1665 Antilley Road, Suite 285 Abilene, Texas 79606
Office 325.793.5128

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by ***Image Sculptors at ADC*** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of ***Image Sculptors at ADC***. I understand that diagnosis or treatment of me by Image Sculptors may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ***Image Sculptors at ADC*** is not required to agree to the restrictions that I may request. However, if ***Image Sculptors at ADC*** agrees to a restriction that I request, the restriction is binding on ***Image Sculptors at ADC and Dr. Laura L. Bennett and Dr. Peter C. Grothaus***. I release all medical records to Image Sculptors, and all records created at ***Image Sculptors at ADC*** are the property of Image Sculptors.

I have the right to revoke this consent, in writing, at any time, except to the extent that ***Image Sculptors at ADC*** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review ***Image Sculptors at ADC*** ‘s Notice of Privacy Practices prior to signing this document. The ***Image Sculptors at ADC***'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ***Image Sculptors at ADC***. This Notice of Privacy Practices also describes my rights and the ***Image Sculptors at ADC*** 's duties with respect to my protected health information.

Image Sculptors at ADC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the ***Image Sculptors at ADC***’s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative	Date
Print Name of Patient or Personal Representative	Description of Personal Representative’s Authority

Image Sculptors
Plastic Surgery and Day Spa

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Please initial beside each paragraph. Where appropriate please **circle** the desired response

1._____ I consent to the taking of photographs by Image Sculptors or staff designee of me or parts of my body in connection with the plastic surgery procedures(s) to be performed by Image Sculptors. I understand my photograph will be taken prior to each and every treatment and saved for evaluation throughout the treatment process. (required)

2._____ I hereby grant permission for the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc. (required)

3._____ I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire twenty years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Image Sculptors. (required)

4._____ I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because all parties acting under Image Sculptors license and authority are not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by parties acting under Image Sculptors license and authority. (required)

5._____ I release and discharge Image Sculptors, and all parties acting under his/her license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs. (required)

6._____ I (do/do not) grant permission of the use of any of my medical records including illustrations, photographs or other imagine records created in my case, ***for use in teaching purposes***, **so long as my identity is kept confidential, by removing all identifying features**. Teaching purposes include, but are not limited to: teaching seminars, medical publications and medical presentations.

7._____ I (do/do not) grant permission of the use of any of my medical records including illustrations, photographs or other imaging records created in my case, for use in advertising, so long as every attempt is made to keep my identity confidential.

I grant this consent as a voluntary contribution and certify that I have read the above Authorization and Release and fully understand its terms.

Patient **X**_____ Date _____

WITNESS/PHYSICIAN: _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian _____ *Date* _____

1665 Antilley Road, Suite 285 Abilene, Texas 79606
Office 325.793.5128

Image Sculptors
Plastic Surgery and Day Spa

Medical History

Tell us your interest, and concerns: Please Circle

Sun Spots	*Flushing of the skin*	*Botox*
Wrinkles	*Large Pores*	*Fillers*
Spider Veins	*Hair Removal*	*Plastic Surgery*

How long have you considered cosmetic procedures? _____

Have you noticed your skin problems worsening? _____

Have you ever been treated for this problem before? Yes No
If yes, when? _____
By what method? _____

Are you currently taking medication for your skin problem? Yes No
If yes, what medication? _____

Are you pregnant, nursing or planning pregnancy soon? Yes No
If yes, please explain: _____

Do you have a history of keloid scarring? Yes No
Do you have a history of? Please Circle

Heart Disease	*Diabetes*
Herpes/cold sores	*Bleeding Disorders*
Bruising	*Dark spots after pregnancy*
Skin Injury	*Skin cancer or suspicious moles*

Have you had any allergic reactions to anesthesia? Yes No
If yes, please explain: _____

Do you have any skin related allergies? Yes No
If yes please list: _____

Do you have any allergies to medication? Yes No
If yes, please list: _____

Do you take any of these medications? Circle all that apply

Aspirin	*Anti-coagulates (blood thinners)*
Hormones/contraceptives	*Appetite suppressants (diet pills)*
Thyroid medication	*Insulin*
Sedatives	*Tranquilizers*
Cortisone	*Accutane*

Other (Please specify: _____*)*

1665 Antilley Road, Suite 285 Abilene, Texas 79606
Office 325.793.5128

Are you taking any herbal preparations? (Ex. St. Jon's Wort) Yes No
If yes, please list: _____

What is your daily consumption of alcohol? _____

Do you smoke? Yes No
If so, how often? _____

Do you wear contact lenses? Yes No

Have you had cold sores or fever blisters? Yes No
If yes, how often? _____

When was the last time you were exposed to the sun or a tanning bed? _____

Do you use chemical sun tan lotions? Yes No
If yes, please list: _____

Are you planning a vacation in the sun? Yes No

Have you ever had skin resurfacing, rejuvenation or chemical peels? Yes No
If yes, when was your last treatment? _____
What type of treatment did you have? _____

Have you ever had treatments for pigmented lesions? Yes No
If yes, when was your last treatment? _____
What type of treatment did you have? _____

Please explain any additional information you think we may need to know:
_____

*Signature:*_____*Date:*_____

1665 Antilley Road, Suite 285 Abilene, Texas 79606
Office 325.793.5128

PATIENT CONSENT FORM
FOR LIGHT BASED HAIR REMOVAL

I hereby authorize Dr.Grothausor any delegated associates to perform light based hair removal on me. I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I also understand some people may not experience complete hair loss even with multiple treatments and that it is only effective on hair with color and does not treat white, grey, blonde, or red hair. I understand that genetics, hormones, and hair color may interfere with hair loss and that I may not respond at all.

I am aware of the following possible experiences/risks:

- DISCOMFORT – Some discomfort may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.
- PIGMENT CHANGES (Skin Color) – During the healing process, there is a possibility that the treated area can become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office at 325.793.5128.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the changes of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from injury.

The following points have been discussed with me:

- Potential benefits of the proposed procedure
- Possible alternative procedures such as electrolysis, waxing, plucking and depilatories
- Probability of success
- Reasonably anticipated consequences if the procedure is not performed
- Most likely possible complications/risks involved with the proposed procedure and subsequent healing period
- Post-treatment instructions

For women of childbearing age: By signing below I indicate that I am not pregnant. Furthermore, I agree to keep Dr.Grothausand staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do___do not___authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LIGHT BASED HAIR REMOVAL TREATMENT, AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature-Patient or Guardian	**Print Name/Relationship**	**Date**
Signature-Witness	**Print Name**	**Date**

Post Care Treatment Laser Hair Removal

Post treatment discomfort can be relieved with Ibuprofen, cold compresses or an ice pack. Apply 10 minutes at a time repeating every few hours if discomfort persists. Shower with cool water on the treatment area.

A sunscreen with an SPF 30 must be applied 15 minutes prior to casual sun exposure. Reapply every 2 hours or after swimming. Also please remember no self tanners, sun exposure, tanning beds 2-3 weeks prior to treatments.

Ointment can be applied to the area to prevent drying and crusting.

You may shave the treated area 3 days following treatment. No tweezing or waxing or use of chemical defoliant between treatments**. Please do not shave or trim the treated area for the first 3 days.**

The treated hairs may take 7-14 days to exfoliate and may appear to be "growing" during this time. Blistering can occur during the first three days following laser procedure. Blistered areas should be treated with care, keeping the area moist with an ointment until the area has healed. Some patients develop raised papules similar to hives; this irritation usually subsides in a few hours.

Recommended time interval between treatments is a minimum 4-6 weeks

Please call our office if you have any problems or questions. 325-793-5128

Image Sculptors
Plastic Surgery Medical Day Spa
Dr. Laura L. Bennett Dr. Peter C. Grothaus

CONSULTATION FORM
FOR THE LIGHT BASED PROCEDURES

Date: _____

Name: _____Age: _____

Treatment Area: _____ Fitz. Skin Type: I II III IV V VI

Past Medical History: _____

Pregnant _____Yes _____No

Current Medications: _____

Allergies: _____

History:	**Yes**	**No**	**N/A**	**Date**
Recent Sun Exposure	X	X	X	_____
Previous Laser Treatments	X	X	X	_____
Hair Removal				
Waxing, Plucking, Electrolysis	X	X	X	_____
Accutane, last 6 months	X	X	X	_____
Gold Therapy	X	X	X	_____
Coagulopathies	X	X	X	_____
Herpes/Cold Sores	X	X	X	_____
Vitiligo	X	X	X	_____
History Melanoma	X	X	X	_____
Keloids/Hypertrophic Scarring	X	X	X	_____
Tattoos/Permanent Make-up	X	X	X	_____
Fillers, Botox etc.	X	X	X	_____
Pacemaker/Defibrillator	X	X	X	_____
Implants/Surgeries in treatment area	X	X	X	_____

Initial:

_____ Benefits of procedure discussed
_____ Contraindications reviewed
_____ Risks reviewed
_____ Probability of success reviewed
_____ Alternative procedures available
_____ Consent signed
_____ Verbal and written post-treatment instructions given to patient
_____ Pre-op photos taken
Appointment scheduled: Date: ____/____/____

Revised 03/09/09

Comments

Image Sculptors
Plastic Surgery Medical Day Spa
Dr. Laura L. Bennett Dr. Peter C. Grothaus

Skin Typing Matrix

Name: _____

Please answer the following questions by circling the number which best describes you. Your clinician will total your score during the consultation.

My ethnic origin is closest to: Please Circle One
Very fair
Fair-Skinned Caucasians with light hair and light eyes
Pale-Skinned Caucasians with dark hair and dark eyes
Olive-Skinned (Mediterranean, Some Asian, Some Hispanic)
Dark-Skinned (Middle Eastern, Hispanic, Asians, Some Africans)
Very dark-skinned

My eye color is:

0 Light Blue
1 Blue Green
2 Green/ Gray/ Golden
3 Hazel/ Light Brown
4 Brown

My natural hair color at age 18 was:

0 Red
1 Blonde
2 Light Brown
3 Dark Brown
4 Black

The color of my skin that is not normally exposed to the sun is:

0 Pink to reddish
1 Very Pale
2 Pale with a beige tan
3 Light brown
4 Medium to dark brown
5 Dark brown- Black

If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:

0 Burn, blister and peel
1 Burn, then when burn resolves there is little or no color change
2 Burn, but then turns to tan in a few days
3 Get pink, but then turns to tan quickly
4 Just tan
5 Just gets darker
6 My skin color is so dark I can't tell

When was the last time the area to be treated was exposed to natural sunlight, tanning booths or artificial tanning cream?

0 Longer than one month ago
1 Within the past month
2 Within the past two weeks
3 Within the past week

If your score is:	Your skin type is:
0-3	1
4-7	2
8-11	3
12-15	4
16-19	5
20-24	6