NEW PATIENT GENERAL INFORMATION FORM

First Name_____ Middle Initial_____ Last Name_____

SS#_____ Gender_____ Date of Birth_____

Street Address_____

City _____ State _____ ZIP Code _____

Home Phone # _____ Cell # _____

Email Address _____ Marital Status _____

Occupation _____ Employer_____

Pharmacy _____ Pharmacy Phone_____

Emergency Contact _____ Relationship_____

Emergency Contact Phone _____ Emergency Contact Email_____

How did you hear about us?

AUTHORIZATIONS: I understand that payment for services provided by LA Wellness Boutique will be my responsibility. My insurance carrier will not be billed for these. In addition, my signature below constitutes my consent for treatment.

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, court costs, and all other costs related to the collection of this debt.

Signature _____ Date_____

Print Name _____

AESTHETICS MEDICAL HISTORY

Name: _____

Women: Are you pregnant or breastfeeding? _____

Primary Physician's Name_____

MEDICAL CONDITIONS:

	Yes	No		Yes	No
Myesthenia Gravis			Diabetes		
Multiple Sclerosis			High Blood Pressure		
Amyotrophic Lateral Sclerosis			Heart Problems		
Eaton Lambert Disorder			Herpes/Cold Sores		
Parkinson's disease			Skin Disease		
Seizure Disorder			Current Skin Lesions		
Numbness/Muscle Weakness			Keloid Scarring		
Vision Problems			Current Infection		
Eye Disease			HIV/AIDS		
Autoimmune Disease			Hepatitis		
Arthritis			Hormone Imbalance		
Cancer			Thyroid Imbalance		
Bleeding Disorder					
Blood Clots					

ALLERGIES (please list):

_____

_____

Have you specifically ever had an allergic reaction to any of the following? **Circle:**

Aspirin Lidocaine (Anesthetic) Hydrocortisone Eggs

Latex Hydroquinone or skin bleaching agents

MEDICATIONS (include over the counter, hormone therapies, oral contraception & supplements):

_____

_____

_____

_____

Are you currently taking any of the following?

	Yes	No		Yes	No		Yes	No
Aspirin			Vitamin E			Garlic		
Blood Thinners			Fish Oil			Ginger		
Hormones			Omega 3			Cayenne		
Antidepressant or Anxiety Med			Ginko			Licorice		
Flax Seed Oil			CoQ10					

Are you taking any antibiotics to treat bacterial infections? **Circle** Yes / No
If yes, please explain: _____

_____

_____

Any previous Hospitalization/Operations? **Circle** Yes / No
If yes, please explain:_____

_____

_____

FACIAL HISTORY
What bothers you most about your facial appearance? _____

What are your expectations for today's visit? _____

Do you regularly sun bathe or use tanning salons? If yes, how often? _____

Are you currently using any RetinA or bleaching creams? If yes, please list:_____

_____

Have you waxed, tweezed, bleached or used hair removal cream within the last week? If yes, please specify: _____

Have you ever had botox or dermal fillers? If yes, When were you last treated: _____
Any complications? If yes, please specify: _____

Have you taken any Aspirin, Ibuprofen, Motrin, Fish Oil, Vitamin E, Blood Thinners, Alcoholic Beverages in the last ten days? If yes, what? _____

FACIAL INJURY TRAUMA HISTORY

Is there any history of facial surgery? If yes, please describe:

_____

Is there any recent history of trauma to the head or face? If yes, please describe:

_____

Any TMJ problems like jaw pain, clenching or teeth grinding? If yes, please describe:

_____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature:_____Date:_____

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

LA Wellness Boutique is committed to providing you with the best possible care. In order for us to achieve this goal, we need your assistance and understanding of our financial policy. Please read the following carefully. As it is an agreement that you are responsible for payment, and will pay in a timely manner.

- All professional services rendered by LA Wellness Boutique are charged to the patient. Patients are responsible for all fees regardless of insurance coverage. LA Wellness Boutique does not file any insurance claims and does not code visits for any insurance.
- All payments are due at the time of service. We accept cash, checks and credit cards for your convenience.
- In order to release our medical records, we must receive a release signed by the patient or legal guardian.
- There is a $50 fee on any returned checks that will be electronically debited from your account.
- Any lab work will be billed by the vendor. There is an option to use your insurance to cover your lab costs. The vendor will require your insurance information and it is for this reason that we keep a copy of your insurance of your chart with us.
- By providing us with your landline or cell phone number(s), you give your consent for us, our agents, and to our collection agents, to contact you at these numbers, or at any number that is later acquired for you, and, to leave live, or pre-recorded messages regarding any accounts or services. Providing us a telephone or cell number is not a condition of receiving our services, however.

Agreement to Accept Financial Responsibility

I, _____ ,acknowledge that, at my request, LA Wellness Boutique has provided or will provide me with professional services, and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and if my account becomes past due, it will become eligible for collections activity. I understand that any expense incurred by LA Wellness Boutique in its efforts to collect remittance will be added to my bill and become my responsibility. Patients will not be seen by the provider until account is up to date.

I hereby understand that the providers of LA Wellness Boutique will not furnish medical information to any insurance carrier for payment. I understand that I am responsible for the total of fees incurred during my office visit.

Patient Name_____

Patient/Guarantor Signature_____

Relationship to Patient_____

Date_____

HIPAA and Office Privacy Policy

Patient Name _____

DOB_____

I understand that under HIPAA, I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Conduct normal healthcare operations, such as quality assessments and provider certifications.

I have been informed by you or your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization at any time to obtain a current copy of the Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practice.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry our treatment or obtain payment of health care operations. I also understand you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this consent.

PATIENT AUTHORIZATIONS

Please write the name of the person to whom you wish us to disclose your health information:

___Spouse:_____

___Parents:_____

___Children:_____

___Other:_____

___May leave on answering machine/voicemail

___May correspond by electronic means, including text, email, video call, FaceTime, Zoom and Skype

___DO NOT release any medical information to anyone

Signed:_____ Date _____

(Relationship to patient _____)

Consent for Aesthetic Treatments During COVID-19 Pandemic

I, _____, understand that I am opting for an elective treatment/ procedure/surgery that is not urgent and may not be medically necessary. I understand that the option to have virtual consultations is a possibility.

I understand that COVID-19 is believed to be spread by person-to-person contact and, as a result, federal and state health agencies recommend social distancing. However, I understand that physical distancing of 6 feet may not be possible while receiving treatments in the office of Dr. Sayeh Eshraghi, MD.

I understand that I must wait in my car and call or text (818-858-1182) upon arrival so that a temperature check can be done prior to entering suite 107 and the office of Dr. Sayeh Eshraghi, MD. I also agree to sanitize my hands before entering the office and that I must wear a mask that covers my mouth and nose while in common areas.

Please read ALL the following statements and check off all the statements that apply to you:

- I confirm that I am not currently positive for the novel coronavirus and I am not waiting for the results of a laboratory test for the novel coronavirus.
- I verify that I have not traveled outside of California by air, cruise ship, car, bus, or train in the past 14 days.
- I verify that I have not been identified as a contact of someone who has tested positive for the novel coronavirus or been asked to self-isolate by health care providers, the Communicable Disease Control or any other government agency.
- I confirm that I am not presenting with any of the following symptoms of COVID-19:
  - Fever > 38°C
  - Flu-like symptoms: Cough, Sore Throat, Chills o Shortness of Breath; Difficulty Breathing
- I confirm that I am not in a high risk category for increased illness or death from COVID-19, including: diabetes, cardiovascular disease, hypertension, lung diseases including moderate to severe asthma, being immunocompromised (including transplant recipient), having active malignancy, or over the age of 65.
- I understand that I may be unable to proceed with certain procedures at the office of Dr. Sayeh Eshraghi, MD, if the procedures are deemed unsafe to myself or a staff member.
- I understand that I may NOT bring family members– including children, friends, pets and/or any other individuals, into the office of Dr. Sayeh Eshraghi, MD, if they do not have an appointment.

I understand that the staff of Dr. Sayeh Eshraghi, MD will do everything possible to minimize the spread of COVID-19 by wiping all hard surfaces, such as door handles, iPads, payment terminals, and countertops before, in-between and after each patient, and thus, they cannot be held responsible should I contract COVID-19.

I will immediately notify the office of Dr. Sayeh Eshraghi, MD, if I contract the virus within two weeks following my visit.

I verify the information I have provided on this form is truthful and accurate.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____