RED MOUNTAIN
MED SPA

New Patient Information

Last Name: ______________________ First Name: ______________________ M.I. ________

Date of Birth: __________ Age: ________ Marital Status: ______________ Gender: ◯ Male ◯ Female

Address: ____

City: ______________ State: ____________ Zip Code: __________

Cell Number: ________________ Home Number: ________________

Email: ____

Primary Care Physician:

Office Name: ________________ Provider: ________________ Phone: __________

Emergency Contact:

Name: ________________________ Relationship: ____________

Cell Number: ________________ Work/Home Number: ________________

Preferred Method of Contact:

With my permission, this establishment and all subsidiaries*, may contact me and leave voice mail messages in reference to any subject that assists in carrying out patient relations, such as, but not limited to: appointment reminders and laboratory results.

My preferred method of contact: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

Patient or Legal Guardian's Signature: ________________________ Date: __________

How did you hear about our office? (Please be specific):

____

____

What are your favorite radio stations? ________________________

What magazines do you read? ________________________

What news publications do you read? ________________________

What websites to you read? ________________________

Areas of concerns, procedures, and/or products of interest to you: (Please check all that apply)

☐ Botox or Dysport ☐ Retin-A or Retinol ☐ Skin Rejuvenation ☐ Laser Resurfacing

☐ Juvederm/Restylane Dermal Filler ☐ Microdermabrasion ☐ Hair Removal ☐ Acne

☐ Sun Damage/Age Spots ☐ Cellulite Reduction ☐ Spider Vein Treatment ☐ Skin Care Advice

☐ AHA, Glycolic or Chemical Peel ☐ Longer Eyelashes ☐ Removing Facial Veins ☐ Weight Loss

☐ Facial & Eye Treatments ☐ Skin Care Products ☐ Body Contouring ☐ Hormone Therapy

☐ Other: ____

Would you like to receive emails from Red Mountain Weight Loss & Red Mountain Med Spa? ☐Yes ☐No

*Red Mountain Med Spa, Red Mountain Weight Loss, Tucson Medical Weight Loss, Tucson Medical Weight Loss & Med Spa

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HEALTH INFORMATION

Have you been under the care of a physician, dermatologist or other medical professional within the past year? ◯ No ◯ Yes, please explain:

____

Have you had any recent surgeries, including plastic surgery? ◯ No ◯ Yes, please explain:

____

Do you see a dermatologist for regular skin checks? ◯ No ◯ Yes If yes, how often: ________ Last skin check: ________

Have you ever had skin cancer? ◯ No ◯ Yes, please explain: ______________________________

Have you ever had aesthetic treatments? ◯ No ◯ Yes, when: ______________________________

Do you have any piercings, tattoos or permanent make-up? ◯ No ◯ Yes, where: ______________________________

Have you had any of these health conditions in the past or present?

Cancer	☐	Headaches (Chronic)	☐	Hormone Imbalance	☐
High Blood Pressure	☐	Hepatitis	☐	Systemic Disease	☐
Hernia	☐	Herpes	☐	Insomnia	☐
Spinal Injury	☐	Frequent Cold Sores	☐	Keloid Scarring	☐
Thyroid Condition	☐	Fever Blisters	☐	Skin Disease/Skin Lesions	☐
Hysterectomy	☐	Immune Disorders	☐	Any Active Infection	☐
Diabetes	☐	HIV/AIDS	☐	Epilepsy	☐
Heart Problem	☐	Lupus	☐	Seizure Disorder	☐
Varicose Veins	☐	Metal Bone Pins or Plates	☐	Arthritis	☐
Asthma	☐	Phlebitis, Blood Clots, Poor Circulation	☐	Eczema	☐
Blood Clotting Abnormalities	☐	Psychological Treatment	☐	Rosacea	☐

If conditions, please explain: ______________________________

Has your physician discussed concerns about raising your body temperature? ◯ No ◯ Yes, please explain: ______________________________

____

Do you smoke? ◯ No ◯ Yes

Do you follow a regular exercise program? ◯ No ◯ Yes

Current Medications: ______________________________

Current OTC Medications (including vitamins, supplements, aspirin, etc.)? ______________________________

____

Medication Allergies: ______________________________

Allergies: ______________________________

Do you use Retin-A, Renova, Deferin, Glycolic Acid, AHA, Salicylic Acid, Topical Antibiotics, or Retinol/Vitamin A derivative products. If yes, describe which and the frequency of use: ◯ No ◯ Yes

____

Have you used any acne medication? ◯ No ◯ Yes

If yes, which? ______________________________

Do you form thick or raised scars from cuts or bruises? ◯ No ◯ Yes

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New Patient Information

HEALTH INFORMATION

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ◯ No ◯ Yes

If yes, describe: ______________________________

List your approximate daily consumption of: Water: __________ Caffeine: __________ Alcohol: __________

Do you wear contact lenses? ◯ No ◯ Yes

Do you have any metal implants or wear a pacemaker? ◯ No ◯ Yes

Have you ever experienced claustrophobia? ◯ No ◯ Yes

Have you ever ever had an adverse reaction after using a skin care product? (Please mark all that apply):

☐ Rash ☐ Irritation ☐ Peeling ☐ Sun Sensitivity ☐ Breakout ☐ Other: __________

Have you ever had an allergic reaction to any of the following? (Please mark all that apply and explain):

☐ Cosmetics ☐ Medicine ☐ Food ☐ Animals ☐ Sunscreens ☐ Iodine ☐ Pollen ☐ AHAs
☐ Fragrance ☐ Shellfish ☐ Latex ☐ Drugs ☐ Other: __________

Please explain: ______________________________

FEMALE PATIENTS - ONLY

Do you have regular menstrual cycles? ◯ No ◯ Yes If no, please explain: __________

Are you taking oral contraceptives? ◯ No ◯ Yes If yes, which?: __________

Any recent changes to or from your contraceptive method? ◯ No ◯ Yes If so, what & when? __________

____

Are you pregnant? ◯ No ◯ Yes

Are you trying to become pregnant? ◯ No ◯ Yes

Are you lactating? ◯ No ◯ Yes

Have you had birth via c-section within the last year? ◯ No ◯ Yes

Are you experiencing any menopause problems? ◯ No ◯ Yes

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AESTHETIC SKIN TYPE ASSESSMENT

GENETIC DISPOSTION	0	1	2	3	4
What color are your eyes?	☐ Light Blue, Gray or Green	☐ Blue, Green or Gray	☐ Blue	☐ Dark Brown	☐ Brownish Black
What is the natural color of your hair?	☐ Sandy Red	☐ Blonde	☐ Chestnut or Dark Blond	☐ Dark Brown	☐ Black
What is the color of your skin in unexposed areas?	☐ Reddish	☐ Very Pale	☐ Pale with Beige Tint	☐ Light Brown	☐ Dark Brown
Do you have freckles on unexposed area?	☐ Many	☐ Several	☐ Few	☐ Incidental	☐ None
				Total Score for Genetic Disposition:	

REACTION TO SUN EXPOSURE	0	1	2	3	4
What happens when you stay too long in the sun?	☐ Painful, redness, blistering, peeling	☐ Blistering followed by peeling	☐ Burn sometimes followed by peeling	☐ Rarely Burn	☐ Never had burns
To what degree do you tan?	☐ Hardly or not at all	☐ Light tan color	☐ Reasonable tan	☐ Tan very easily	☐ Turn dark brown quickly
Do you turn tan within several hours after sun exposure?	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always
How does your face react to the sun?	☐ Very Sensitive	☐ Sensitive	☐ Normal	☐ Very Resistant	☐ Never had a problem
				Total Score for Sun Exposure:	

TANNING HABITS	0	1	2	3	4
When did you last exposure your body to sun, tanning bed or self tanner?	☐ More than 3 months ago	☐ 2-3 months ago	☐ 1-2 months ago	☐ Less than a month ago	☐ Less than 2 weeks ago
Did you expose the area to be treated to the sun?	☐ Never	☐ Hardly Ever	☐ Sometimes	☐ Often	☐ Always
				Total Score for Tanning Habits:	

SUMMARY	
Total Score for Genetic Disposition:	
Total score for Reaction to Sun Exposure:	
Total score for Tanning Habits:	
Total Skin Type Score:	

SKIN TYPE SCORE	FITZPATRICK SKIN TYPE
0-7	☐ I
8-16	☐ II
17-25	☐ III
25-30	☐ IV
Over 30	☐ V

Patient or Legal Guardian's Signature: ______________________ Date: __________

RED MOUNTAIN MED SPA

New Patient Information

Office and Financial Policies

We would like to thank you for choosing us for your medical and aesthetic needs. As one of our patients, we would like to keep you informed of the current office and financial policies for this establishment and all subsidiaries*.

Please read each of the following sections carefully and initial:

Insurance:
This establishment and all subsidiaries* do **NOT** participate with any insurance companies. We are not able to bill your insurance and cannot accept payment from insurance for the services performed or prescriptions received. The medical providers do not use diagnosis codes or CPT codes, and because of this, we are unable to complete forms for patient reimbursement from insurance companies.

Initial: __________

Payment:
ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE, however, some services may require a deposit in advance. This establishment and all subsidiaries* only accepts payment in the form of cash, VISA, MasterCard, American Express or Discover, Advance Care Card and Care Credit. **WE do NOT accept checks.**
*Care Credit cannot be combined with any offer, special or discount, and minimum purchase required.

Initial: __________

Refund Policy:
ALL SALES ARE FINAL. Before a service is performed please consider all the required protocols and side effects. We are committed to patient satisfaction and are available to answer any questions or concerns you may have in regards to the services we offer.

Initial: __________

Appointments:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We require a 24 hour notice for canceling or rescheduling of any appointment. **There is a charge of $50.00 to $150.00 per hour for missed or late-canceled appointments**. Excessive abuse of scheduled appointments may result in discharge from the practice.

Initial: __________

Guarantee:
As in any procedure, treatment or program, there is no guarantee of any particular results. Results will vary based on each individual patient.

Initial: __________

Electronic Recording:
To ensure confidentiality and privacy, the use of any type of recording device by a patient while in any of our offices is strictly prohibited. This includes the use of cameras, audio recording devices and camera phones. Using these devices breaches the confidentiality rights of patients and infringes on the privacy rights of our employees. Patients are welcome to take notes during their office visits. Additionally, all conversations between the medical provider and patient are documented in the patient's medical chart. To review this information, a patient may request a copy of their medical records.

Initial: __________

Services Policy:
I understand that this establishment and all subsidiaries* have the right to refuse treatment to and/or dismiss a client from any service, at any time. I also understand that I may not be a candidate for certain services and it is at the full discretion of the aesthetician/medical provider to determine whether I am a candidate for any service provided.

Initial: __________

I have read, understand and agree to the office and financial policies set forth by this establishment and all subsidiaries*.

Patient or Legal Guardian's Signature: ______________________________ Date: ____________

Patient's Name (Please Print): ______________________________

At your request, a copy of these policies can be provided for you.

*Red Mountain Med Spa, Red Mountain Weight Loss, Tucson Medical Weight Loss, Tucson Medical Weight Loss & Med Spa

RM RED MOUNTAIN MED SPA

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Notice of Privacy Practices

In accordance with HIPAA federal regulations, this establishment and all subsidiaries* will not disclose any information about you or your personal health, without your permission. All information received while a patient (and if/when you decline to be a patient no longer) will be kept confidential.

Patient Consent for Use and Disclosure of Protected Health Information

By signing this form, you consent to the use and disclosure of your protected health information by our staff, and our business associated ***strictly for the purpose of treatment, payment and health care operations.***

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practices*** carefully. It provides more detail on how we may use and disclose of your information. The ***Notice of Privacy Practices*** may change. A current copy may be requested when you are being seen as a patient, by contacting our office manager.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing; however, we reserve the right to deny your request. If we grant your request, we are bound by the terms of agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment or health care operations. Refer to the ***Notice of Privacy Practices*** for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information ***for the purposes of treatment, payment and health care operations.***

Patient or Legal Guardian's Signature: ______________________ Date: __________

Patient's Name (Please Print): ______________________

For Practice Use Only:

For Practice Use Only:

Check the appropriate reason:

- ☐ Indirect Treatment Relationship
- ☐ Emergency Treatment
- ☐ Substantial Communication Barrier
- ☐ Refusal to Sign

Description: ______________________

Practice Signature: ______________________ Date: __________

Witness: ______________________ Date: __________

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Cancellation Policy

I understand that I am responsible for the following fees, if a 24 hour notice to reschedule or cancel my appointment is not given. These fees also apply to missed appointments.

• Weight Loss Appointments:	$25.00
• Hormone Treatment Appointments:	$50.00
• Injectable Appointments:	$50.00
• Aesthetic Appointments:	$50.00
• Body Contouring:	$150.00/Treatment Hour

I understand that I will be billed for this fee and payment is due before I can reschedule my next appointment.

Patient or Legal Guardian's Signature: ______________________ Date: __________

Patient's Name (Please Print): ______________________