

**SANTA ANA SKIN CARE CLINIC
683-B HARKLE RD
SANTA FE, N.M. 87505**

FIRST NAME: _____ **LAST NAME:** _____

DATE OF BIRTH: ____/____/____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

WORK #: _____ **HOME #:** _____

SS#: _____

WHO REFERRED YOU TO OUR OFFICE? _____

Thank you for choosing our office for all of your skin care needs. If at any time you have questions regarding your treatment please feel free to call the office. Please note that treatment fees are due at the time of services, and medical insurance does not cover treatments because they are considered a cosmetic luxury. Also note that the results of products and procedures are not guaranteed. Also all products and services offered through Santa Ana Skin Care Clinic are **non-refundable**.

**SIGNATURE OF
RESPONSIBLE PARTY**

DATE

Mesotherapy

MEDICAL HISTORY

Do you currently or have you ever had any of the following?

Diabetes	_____	Irregular menses	_____
Hepatitis	_____	Heart problems	_____
Herpes	_____	Hysterectomy	_____
Menopause	_____	Hypertension	_____
Sensitive to anesthetic	_____	Photosensitive Disorder	_____
Lupus	_____	Autoimmune illness	_____

Are you under the care of a physician? _____

Current/Recent medications _____

			<u>IF YES, EXPLAIN</u>
Keloid scars	Yes	No	_____
Hives	Yes	No	_____
Skin Cancer	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Cold Sores	Yes	No	_____
Hypersensitivity to skin products	Yes	No	_____
Skin Infections	Yes	No	_____
Tanning within the last 6 wks	Yes	No	_____
Use of acne products/drugs	Yes	No	_____
Laser skin resurfacing	Yes	No	_____
Chemical Peels	Yes	No	_____
Photo sensitizing substances	Yes	No	_____
Laser work of any type	Yes	No	_____

Medical Illness _____

Are you pregnant? _____

Allergies of any kind including drugs _____

Areas of interest for aesthetic treatment _____

Type of treatment requested (fat/cellulite) _____

I ATTEST THE ABOVE INFORMATION TO BE TRUE, KNOWING MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature _____ **Date** _____

PATIENT INFORMED CONSENT AND DISCLAIMER FOR
MESOTHERAPY

PLEASE READ AND INITIAL THE FOLLOWING SENTENCES TO CONFIRM THAT YOU ARE AND CLEARLY UNDERSTAND THEM.

1. I understand that I am requesting my health care professional to perform Phosphatidylcholine (PPC) Injections, a form of Mesotherapy, where my health care professional will anesthetize my skin with a topical anesthetic, then following this inject subcutaneously (under the skin) a local anesthetic and then Phosphatidylcholine (PPC). The local anesthetic and PPC are both injected under the skin. Patient Initials _____

OR

2. I understand that I am requesting my health care professional to perform Phosphatidylcholine (PPC) a form of Mesotherapy subcutaneous injections of Phosphatidylcholine, an outpatient procedure. Patient Initials _____

Mesotherapy with the subcutaneous (under the skin) administration of Phosphatidylcholine (PPC) is the identified outpatient treatment, referred to as the “PROCEDURE” in then following.

1. _____ I understand the Procedure will be preformed by _____ (“my health care professional”) on this ____ day of _____ 2007/2008.
2. _____ I am requesting the procedure be preformed on (Choose One Area) the sides of the abdomen, front of abdomen, thighs, upper arms, chin, neck, infraorbital (fat pad below the eyes), buttock area, area between bra straps and underarms, above the knees, state precise location) _____
3. _____ The nature of the Procedure, the possible complications and risks, as well as the possible benefits of the Procedure the alternatives to the Procedure and the risks and benefits of those alternatives have been explained to me in language and using terminology that I understand. My health care professional has personally answered all of my outstanding questions about the procedure.
4. _____ I fully understand that this Procedure is an elective aesthetic procedure, and that there is no emergency of medical condition that requires that I have the Procedure.
5. _____ Neither my health care professional nor the staff has made any promises of warranties or guarantees as to the success or effectiveness of the Procedure.
6. _____ I understand that the Procedure may not be effective. I have been advised that I may need several procedures for this procedure to be effective.

7. _____ I understand that after the Procedure I may experience side effects such as pain, discomfort and tingling, burning, swelling, bruising, which may be temporary or could be permanent. I have been advised that I may find some of these side effects difficult to tolerate.
8. _____ I understand that there are numerous risks and complications, both known and unknown, connected with the Procedure. These can include but not be limited to infection that can be localized or could spread throughout my body, hemorrhage or bleeding. Delayed healing, under or over correction and other risks and complications, which are unknown at this time.
9. _____ I understand that the Procedure is a relatively new procedure and that little is known about its long-term safety and effectiveness.
10. _____ I understand that the Procedure does not correct certain health problems including but NOT limited to Diabetes, heart attack or stroke, blood clots, lung problems, stomach or intestinal problems or bladder disease.
11. _____ I understand that the field of Mesotherapy is continuing to evolve and that if I were to postpone my Procedure there is the possibility that new procedures and ingredients of Mesotherapy might be improved or some other procedure might become available.
12. _____ I understand that I will need certain post-Procedure care. I will be dutifully responsible in being strictly compliant with the recommendations from my health care professional that may include, but are not limited to ice and compression dressings, application of an anti-inflammatory cream to be applied to treatment area for 2 days after procedure, etc.
13. _____ I understand that I must immediately report any unusual symptoms, known to me to my health care professional (or her designated on call person) and be especially aware of any slight nature or prominence of persistent chills or fever, redness or increased warmth, excessive bruising or swelling at the site of injection, fatigue, lethargy, decreased appetite, jaundice (yellowing of skin or the whites of the eyes), dark urine, unusual severe itchiness or abdominal pain.
14. _____ I have had the opportunity to ask questions about the Procedure and all of my questions have been answered satisfactorily.
15. _____ I give my healthcare professional permission to use data about my treatment for research purposes. I understand that my name and personal identifying information will remain confidential, unless I give written permission to disclose this information. **(Patient may delete this clause when choosing not to participate in research activities)**

16. _____ I understand that the applicable governing law for this procedure is the law of the State of New Mexico.
17. _____ I understand that I hold only my healthcare professional, and NOT Santa Ana Skin Care Clinic is responsible to me for any and all acts of commission and omissions.
18. _____ I give my healthcare professional to videotape or photograph the procedure.
19. _____ I understand that the Federal Drug Administration (FDA) for ANY type of human benefit does NOT approve Phosphatidycholine (PPC) Injections.
20. _____ I, _____ have decided that the benefits of this form of Mesotherapy of Phosphatidycholine injections outweigh the potential complications.
21. _____ I am not under the influence of any sedative or other medications or recreational substance that could in any way affect my judgment in signing this document or requesting to have this procedure preformed. I am clear of mind and completely understand the nature of the Procedure and ANY and all possible risks mentioned, but NOT limited to all stated risks, which are related to the Proceduree.

I _____ FULLY understand that by signing below, I am indicating that I have read and understood the information in this Patient Consent Form; that I have been verbally advise about the Procedure, that I have had an adequate and reasonable opportunity to ask questions, that I have received all the information I desire concerning the Procedure, all of this information is mentally and physically clear to me, and that I authorize and consent to the performance of the Procedure.

Patient Signature _____ **Date** _____

FINANCIAL POLICY

Please read our financial policy and indicate your agreement by your signature. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. All patients must complete the appropriate information forms before seeing a skin care provider.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. (Unless other arrangements are made directly with the office manager.)

We accept cash, check, Visa, American Express, Discover and Master card.

Private pay patients: Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or paid by cash, check, or credit card at the time of services.

Insured patients: If you have insurance we will help you receive maximum benefits. We will give you properly completed “super bills” so that you can file your own insurance and be reimbursed to the extent of your coverage. We only file claims to insurance companies that we are participating providers for. Filing a claim is not a guarantee of payment. Many of our services are considered to be a cosmetic luxury and are therefore not covered by insurance. You are responsible for the full payment of any denied claims.

Insurance: This is a contract between you and your insurance company. In many cases we are not a party to this contract. We will inform you if we are a party to your contract, and we will handle your claims according to our agreement with your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance usual and customary charges, etc. other than to supply actual information as necessary. You are responsible for timely payment on your account.

Missed appointments: Unless canceled or rescheduled at least 24 hours in advance, our policy is to charge \$50 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Balance due terms: Your signature below indicates your agreement with our terms for any unpaid balance due. Unpaid balances due will begin accruing interest at the rate of 12% per annum, for balance due over 30 days. If it becomes necessary to employ an attorney or collection agency to collect an unpaid balance due, those fees will be added to the balance due. If you are unable to pay a balance due, please discuss payment arrangements with our office manager.

Please Note: All products and services offered through Santa Ana Skin Care Clinic are non-refundable.

Responsible Party Signature _____ Date _____

PRIVACY POLICY

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice summarizes how we handle your information, and provides further details of our privacy policies and procedures.

How we may use and disclose your information: We use health information about you for your treatment, to get paid for treatments, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for these reasons. Beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop further uses or disclosures.

Your rights: In most cases you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we will charge you a cost-based fee and these copies will be made within 30 days. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

Our legal duty: We are required by law to protect the privacy of your health information; provide this notice about our privacy policies; follow the privacy practices that are described in this notice; and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make significant changes in our privacy policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

Privacy complaints: If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

If you have any questions or complaints, please contact:

Elena Winters
683 B Harkle Road
Santa Fe, NM 87505

(505) 954-4422 ext 1004

Responsible party signature _____ Date _____

PROCEDURE CLAIM REVIEW FORM

Santa Ana Skin Care Clinic would like to make you aware that in the in the event that we should submit a claim to your insurance company for a procedure reviewed here at our clinic, your insurance provider always reserves the right to review and deny any claim they receive. We may be able to find out for you if the procedure does not require a pre-authorization, but these procedures are still subject to review and possible denial. The only time your insurance company is obligated to pay any amount is if they give you a confirmed pre-authorization number which we will keep in your chart making you not responsible for payment; unless the treatment amount is applied towards a deductible then you will still be held responsible for payment. Your signature below indicates you agree to abide by the policy in this form.

I _____ have read and understand the Insurance Procedure Claim Review Form.