HEALTH HISTORY INFORMATION

Today's Date: ______________________________

Name: ____
Last First MI

Street address: ____

City: ____ State: ______________ Zip: _________________

Date of Birth: __________________________________ Age: _______________ Sex: ☐ Female ☐Male

Cell Phone: _______________________________________Home Phone: __________________________________

Email address: ______________________________ How did you hear about us? _______________________________

I consent to this email address being added to the Kimiko Medical Aesthetics email newsletter, where I will get information on specials and promotions. ☐ Yes ☐ No

Occupation: ____

In case of Emergency, who should be notified? (name and phone) ____

Do you have any major medical problems, serious illness? ☐ Yes ☐ No

If so, please list:

____

____

Please list all prior surgical procedures and dates performed:

____

____

MEDICAL HISTORY

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

Do you suffer from "photosensitivity" (extreme sensitivity to sunlight)? ☐ Yes ☐ No

Do you have a history of easy/excessive Hyperpigmentation? ☐ Yes ☐ No

Do you form keloid scars? ☐ Yes ☐ No

Do you suffer from seizures? ☐ Yes ☐ No

Do you have any metal implants? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes - packs per day? _______________________

Do you drink alcohol? ☐ Yes ☐ No If yes - quantity per week? ____________________

Please list all allergies:

____

Are you allergic to any medication? ☐ Yes ☐ No

If so, please list:

___

Please list all medications below: ☐ None

Name	Dosage	Frequency	Medical Condition

Are you or might you be pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Do you currently have any of the following (please check all that apply):

- ☐ Active Infection
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blistering Sunburns
- ☐ Circulation Problems/Blood Clots
- ☐ Cold Sores /Shingles
- ☐ Collagen Disorder
- ☐ Diabetes (Type_________)
- ☐ Easy Bruising
- ☐ Eczema
- ☐ Endocrine / Hormonal Issues
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Headaches / Migraines
- ☐ Heart Condition Hepatitis
- ☐ Hernias
- ☐ High / Low Blood Pressure
- ☐ HIV / AIDS
- ☐ Hormonal Imbalance
- ☐ Insomnia / Sleeping Problems
- ☐ Joint Injury
- ☐ Multiple Sclerosis
- ☐ Muscle Pain / Spasms
- ☐ Neurological Disorders
- ☐ Permanent Makeup /Tattoo
- ☐ Pigmentation Disorders
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Recent Surgery
- ☐ Scleroderma
- ☐ Sensitive Teeth
- ☐ Skin Cancer
- ☐ Skin Injury
- ☐ Stroke
- ☐ Unusual Moles
- ☐ Varicose Veins
- ☐ Vision Deficits
- ☐ OTHER ______________________

AESTHETICS & SKIN CARE HISTORY

Have you had unprotected sun exposure or been in a tanning booth in the last 2 weeks? ☐ Yes ☐ No

Please indicate your current skin care products/regimen:

____

____

____

Medical/Treatment History

- Do you currently use depilatories or wax? ☐ Yes ☐ No
  (Discontinue use five days pre- and post-treatment.)
- Have you had a chemical peel or any type of procedures with a medical device ☐ Yes ☐ No
  Within the last 14 days? ☐ Yes ☐ No
  What type? ____
- Have you ever had Botox or other dermal filler injections? ☐ Yes ☐ No
  Last injection? ____
- Have you recently had laser resurfacing or facial surgery ☐ Yes ☐ No
  Describe: ____
  When? ____
- Are you currently taking any medication, topical or otherwise? ☐ Yes ☐ No
  (Tretinoin / Retin-A / Renova / Differin / Tazorac / Avage /EpiDuo / Ziana)
  Which one(s)? ____
  For how long? ____
  What strength? ____
- Have you ever undergone Accutane therapy (isotretinoin)? ☐ Yes ☐ No
- Are you allergic/sensitive to (circle all that apply) milk / apples / citrus / grapes / ☐ Yes ☐ No
  Aloe vera / aspirin / perfumes / latex / hydroquinone / mushrooms?
  If any other allergies, what? ____
- Have you ever used any other products that caused a bad reaction? ☐ Yes ☐ No
  Describe: ____

List any other aesthetic treatments not asked about:

____

____

Patient Signature: ____ Date: ____________________

Provider Reviewed (sign)____________________________________

COSMETIC INTEREST QUESTIONNAIRE

X	Interest	Notes
	Dry or Oily Skin	
	Tired Looking Skin or Uneven Skin Tone or Texture	
	Brown Spots. Sun Damage Or "Hyperpigmentation"	
	Clogged or Large Pores	
	Acne Face or Back	
	Rosacea, Facial Redness, Facial Veins	
	Fine or Deep Wrinkles- list area of concern	
	Lines Above Lips or Around Mouth	
	Facial Volume Loss/ Sagging	
	Neck: Wrinkles, Loose Skin, or chin/jowl Fat	
	Under Eye Hallowing or Wrinkles	
	Lip Lines or Thin Lips or Lip Augmentation	
	Jawline Definition	
	Chin: Wrinkled or Needs Volume	
	Aging Hands	
	Unwanted Facial or Body Hair	
	Scars (Acne or Surgical)	
	Skin Tightening (Face or Body)	
	Excessive Sweating	
	Body Contouring, Fat Reduction, or Cellulite	
	Leg Veins	
	Length or Fullness of Eyelashes, Color of eyebrows	
	Prevention or Maintenance for my skin	
	Interested in Skincare Products	

Client Signature: ____

Provider Signature:____Date: ____________________

ACKNOWLEDGEMENT OF PRACTICE POLICIES

I understand that I will be required to pay a $50 consultation fee that can be applied toward services purchased within 7 days of consultation. In addition, prior to any treatment being performed, I will be required to sign an informed consent. Any treatment performed at Kimiko Medical Aesthetics is cosmetic in nature and the decision to proceed is based on my desire to do so:____________(Please Initial)

PAYMENT POLICY

I understand that my treatments at Kimiko Medical Aesthetics require payment upon services rendered and the prices and fee structure for treatment have been explained to me. The quoted price for treatment is the price for each individual treatment session, unless otherwise specified in writing by Kimiko Medical Aesthetics. For cosmetic medical procedures, I understand that the services often require more than one session to achieve the best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There are no refunds on treatments paid in advance, however any money paid can be used toward another treatment. Any refunds will be determined on a case-by-case basis after appropriate management approval and or sufficient reason. I further understand that the services offered by Kimiko Medical Aesthetics are elective in nature and are not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. We accept payment in the form of cash, check, major credit cards or Care Credit. _____________(Please Initial)

RESCHEDULING/CANCELLATION AND NO SHOW POLICY

We understand that sometimes it is necessary to reschedule or cancel your appointment. If you need to reschedule or cancel, please contact us 24 hours in advance of your scheduled time. Call or text our office at 918-394-2796 or email info@kimikotulsa.com.

All rescheduling/cancellations within the required 24 hours' notice; will result in a $50 fee that will be charged to your card on file. A No Show is considered failure to cancel or failure to show for a scheduled appointment; a $50 fee will be charged to your card on file. This courtesy enables us to compensate our employees for their time, and maintains a higher availability of our time for you as well as others. By scheduling an appointment, you are agreeing to our Rescheduling/Cancellation and No Show Policy. Patients arriving more than 10 minutes late may result in a shortened appointment or a cancellation if there is not enough time to complete the procedure. If your appointment is rescheduled or cancelled due to late arrival you will be charged the $50 cancellation fee. We regret any inconvenience this may cause. ___________(Please Initial)

RETURN POLICY

All sales of skin care and makeup products are final. Unopened products may be returned with a receipt for a credit within 7 days. All treatment services are non-refundable. Management may, at its discretion, allow you to apply the remaining unused balance towards other services. _____________(Please Initial)

DISCLAIMER

I understand that all medical cosmetic treatments are provided exclusively by Kimiko Medical Aesthetics. I will not hold the Kimiko Medical Aesthetics, its owners or its employees responsible for the results I experience. I realize that results may vary. I further understand that Kimiko Medical Aesthetics cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion:___________(Please Initial)

I understand that even with the best laser and the highest trained and board-certified medical providers, there are a percent of patients that are non-responders and will not have a desired response/outcome to treatments. ___________(Please Initial)

CONSENT TO PHOTOGRAPH (check one or both)

☐ I consent to be photographed during the course of my treatment with Kimiko Medical Aesthetics. I understand that the purpose of such photographs is to track the progress of my treatment(s). I understand that my photographs are part of my medical records and therefore, are the property of Kimiko Medical Aesthetics.

☐ I consent to the use of my photographs, at the discretion of Kimiko Medical Aesthetics for marketing (social media or Kimiko Medical Aesthetic website), research, educational and/or scientific purposes. **I understand that every attempt will be made to protect my identity and my name will not be disclosed. If we would like to use a picture that clearly shows your face, we will ask your permission first.**

PRIVACY

I have read and fully understand all the terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent.

Print Patient name: ____

Signature:______________________________________ Date: ____________________

KIMIKO MEDICAL AESTHETICS
NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature: ____