



## Welcome to New Leaf Esthetics!

*It's Time to Turn Over A New Leaf*

*Thank you for choosing New Leaf Esthetics, where we always provide a comfortable, caring environment so our patients can feel at ease. We've included helpful items in this package to ensure your first trip to our office is productive, relaxing and enjoyable. During your first visit, we make sure to obtain important medical history and give you time to get to know your provider. Please proceed to read through the following pages.*



## **Patient Information**

**Name:** \_\_\_\_\_  
(first) (middle) (last)

**Address:** \_\_\_\_\_

**City, State, Zipcode:** \_\_\_\_\_

**Date of birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

**APPOINTMENT REMINDERS? (circle):** EMAIL / TEXT / BOTH

**How did you hear about us?:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Home phone:** \_\_\_\_\_

**Cell phone:** \_\_\_\_\_

## **EMERGENCY CONTACT INFORMATION**

**Emergency contact:** \_\_\_\_\_

**Relation:** \_\_\_\_\_

**Phone number:** \_\_\_\_\_

# When can we reach out to you?

*(check one)*

you can reach me anytime

<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
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- morning
- afternoon
- anytime

- morning
- afternoon
- anytime

- morning
- afternoon
- anytime

- morning
- afternoon
- anytime

- morning
- afternoon
- anytime

<b>Saturday</b>	<b>Sunday</b>
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- morning
- afternoon
- anytime

- morning
- afternoon
- anytime

## **VOICEMAIL**

- Leave call back number only
- O.K to leave message with detailed information

**Medical History**

Are you currently under the care of a physician?  No  Yes

**Name of Doctor:** \_\_\_\_\_ **Doctor's phone number:** \_\_\_\_\_

List any medications you are currently taking: \_\_\_\_\_

Allergies? Please list below:

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**Do you have any of the following conditions?**

- Cryoglobulinemia**
- Cold Agglutinin Disease**
- Paroxysmal cold hemoglobinuria**
- Thyroid disease
- Chest Pain
- HIV/AIDS
- Any active infection
- Epilepsy or seizures
- Bleeding disorders
- Heart Disease
- Sensitive teeth
- Skin cancer or moles
- Skin injury
- Diabetes
- High blood pressure
- Cancer
- Hormone imbalance
- Bruising
- Pacemaker or any implantable device
- Other: \_\_\_\_\_

**Have you had any surgeries in the past 12 months?**

- yes
- no



**Authorization for Release and/or Publication of Photographs\***

**I hereby authorize the release of any/all the photographs taken prior to treatment, during treatment, and after treatment. I consent to these photographs for the following purpose(s):**

- Medical Records**       **Marketing**       **Both**

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Printed name

Date

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Patient Signature

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Provider signature

Date



**HIPAA AND FINANCIAL POLICY**  
**PLEASE READ ALL OF THE FOLLOWING**

**HIPAA:**

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. This ensure that you will receive optimal treatments that are safe for you, based on your personal medical history.

**MISSED APPOINTMENTS/LATE CANCELLATIONS:** 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. Cancellations are requested 24 hours prior to your cosmetic consultations. In the event that you cancel in less than the requested 24 hours you'll be charged a \$50 fee. Our office understands that emergencies do arise, but please call our office to discuss this with a staff member.

**REFUNDS: ALL SALES ARE FINAL, AND NO REFUNDS WILL BE PROVIDED.**

**PAYMENT POLICY: NEW LEAF ESTHETICS DOES NOT TAKE CHECKS.** In order to schedule a treatment and secure your desired date, we must obtain a non-refundable deposit of 30% of your total treatment cost. We accept: Cash, Visa, MasterCard, American Express, and Discover.

Financing options offered: Care Credit

**PATIENT DISMISSAL:** Failure to observe these policies, demonstration of unacceptable behavior, or medical noncompliance can result in dismissal from the practice.



## **ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY PRACTICES AND FINANCIAL POLICY**

I have received a copy of this office's HIPAA Notice of Privacy Practices and Financial policies.  
I was also given time to thoroughly read all forms and ask questions.

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Printed Name

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Signature

Date