Forever Fabulous Permanent Cosmetics

A Medical Spa at Rizzieri

Today's Date _____/_____/_____

Name _____ Date of Birth _____/_____/_____ Email: _____

Ethnic Background, please include all nationalities _____

Address _____ Apt. # _____ City: _____

State _____ Zip _____ Home Phone (____)_____ Cell (____)_____

Occupation: _____ If we call you at home, do you want confidentiality? ☐ No ☐ Yes

May we call you at work? ☐ No ☐ Yes If Yes, my work number is (____)_____

Emergency Contact, Name _____ Phone (____)_____ Relationship_____

Who may we thank for referring you? _____

Procedure(s) desired: ☐ Brows ☐ Eyeliner ☐ Lips ☐ Camouflage ☐ Areola Complex ☐ Correction

List all medications you are presently taking

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you

List all medications you took in the last six months that you are no longer taking:

Name of drug	Mg. or mcg.	How many a day	Why it was prescribed to you?

Practitioner Signature _____ **Date** _____/_____/_____

GENERAL MEDICAL Client Name: _____

Do you have? (check all that apply)

- ☐ **Fever Blisters/Cold Sores** (Ever, even one time)
- ☐ Glaucoma or other eye disease/disorder
- ☐ Grave's Disease
- ☐ Heart Disease
- ☐ Shingles History/Recent Shingles Shot
- ☐ Mitral Valve Prolapse
- ☐ Valve Implants
- ☐ Pacemaker
- ☐ Stents
- ☐ Diabetes requiring insulin
- ☐ Problems with healing
- ☐ Keloids
- ☐ Seizures
- ☐ Dermatological Disorder
  If so, what? _____
  Active or in Flare-ups? _____
- ☐ Hemophilia or Clotting Disorder
- ☐ Autoimmune Disorder
- ☐ Pre-existing nerve damage
- ☐ Tattoos: Colors you are sun sensitive to:

  _____
- ☐ Trichotillomania (pulling of hair, brows, lashes)
- ☐ Alopecia Totalis or Areata
- ☐ Allergies
  List: _____

Are you? (check all that apply)

- ☐ Pregnant
- ☐ Planning cosmetic surgery
  If so, what & when? _____
- ☐ Currently under the care of a physician
  Describe: _____

Do you practice outdoor activities? Circle all that apply

Tennis	Swimming
Golf	Skiing
Gardening	Walking
Boating	Other

Do you use? (check all that apply)

- ☐ Accutane (currently or within the past year)
- ☐ Antibiotics prior to dental procedures
- ☐ Steroids
- ☐ Retin-A, Glycolic Acid, Vitamin C or other Exfoliants
- ☐ Tanning Beds
- ☐ Eyebrow Tinting
- ☐ Eyelash Tinting
- ☐ Latisse
- ☐ Botox When_____
- ☐ Chemical Peels When_____
- ☐ Chemotherapy or Prophylactic dose of Chemotherapy
- ☐ Blood Thinners

Have you had? (check all that apply)

- ☐ **Fever Blisters/Cold Sores** (Ever, even one time)
- ☐ Eye Infections (Are you prone to them)
- ☐ Vision Correction Procedure (Lasik, RK) within the past 3 months
- ☐ Heart Attack - When? _____
- ☐ Joint Replacement, Organ Transplant
- ☐ Eye Trauma
- ☐ Seizures
- ☐ Fainting Spells
- ☐ Hepatitis - What Type: _____
- ☐ Hepatitis Test - When? _____
- ☐ Fat Transfer Injections - If yes, where? _____
- ☐ Gore-Tex Implants - If yes, where? _____
- ☐ Aesthetic or Cosmetic Procedures
  If yes, where? _____
- ☐ Laser Treatments
- ☐ What type & why? _____

Physician's Name: _____
Address: _____
Phone: _____
Specialty: _____

INFORMED CONSENT TO PROCEDURE

1. Are you pregnant or nursing?

   Yes [] No []

Initial

2. I absolutely understand and accept that such procedure is a process, often requiring multiple applications of color to achieve desirable results and the 100% success cannot be guaranteed. _____

3. Depending on the procedure(s), which I select, I accept responsibility for determining the shape, and position of eyebrows, eyeliners, lipliner and/or full lip color. _____

4. I understand that the color selection and color results in all procedures are not an exact science. _____

5. I understand that positioning of my procedures can be affected if I have elected or wish to elect cosmetic surgery, Botox or Restalyne and I assume this responsibility. _____

6. I am aware that if I am to receive an MRI after the procedure, I must tell the Radiologist that I have iron oxide permanent cosmetics. _____

7. If I am a lens wearer, I realize that I must keep my lenses out the day of an **eyeliner procedure**. _____

8. I understand that this procedure will fade, and this fading can alter the original pigment color and that this determines that it is a time for a touch-up visit. _____

9. I realize this is an elective cosmetic procedure and is not medically necessary. _____

10. I have pre-medicated where indicated, prior to my procedure. _____

11. It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration; swelling. _____

12. Although rare, Fever blisters may occur regardless of pre-medication. _____

13. I understand that many lasers & IPL's (Intense Pulse Lights) including those used for hair removal, anti-aging, Photo Facials, removal of lines may or will turn permanent make up dark or even black. I agree to inform my esthetician or anyone operating such that I have permanent make up. _____

14. I give my consent to A Medical Spa at Rizzieri to confer with my physicians for medical information required for the safety of my procedures. _____

15. I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner. _____

16. I am aware that if an infection occurs after I have received Permanent Cosmetics to see with my primary physician or an emergency room, ***immediately***.

17. I have reviewed the aforementioned and understand all pre-procedural instructions, expected outcomes and contraindications. _____

REFUND POLICY: No guarantee can be made that a specific patient will benefit and or be satisfied with the outcome and as such; there will be no refunds.

ACCEPTANCE:
I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

Please read all questions thoroughly before signing!!

Signature of Client X_____

Signature of Practitioner _____ **Date** ____/____/_____

Note: Pricing is determined for this specialized service by Permanent Cosmetic Provider

A Medical Spa
AT RIZZIERI

Authorization to Release and Disclose Photographs

This photographic release pertains to photographs taken during the following treatment:

_____

I, (print name) _____, voluntarily consent to the Copyright, publication, and use of my picture and likeness by A Medical Spa at Rizzieri, affiliates, successors, and assignees.

By signing this form, I am allowing A Medical Spa at Rizzieri, affiliates, successors and assignee to disclose photographs taken of me before, during, and after treatment.

(Please initial either yes or no on each line)

For research, educational informational purposes: **Yes___ No___**
For publications in a medical journal and/or textbook: **Yes___ No___**
For general advertising (print/social media), publicity, or promotional purposes: **Yes___ No___**

I hereby release A Medical Spa at Rizzieri from any claim, demand, cause, action, or proceeding of whatever nature arising out of publication and distribution of the said photographs in accordance with the terms of this release. This release also includes affiliates, successors, and assignees of A Medical Spa at Rizzieri. I also understand that I can revoke (or take away my permission to allow A Medical Spa at Rizzieri to disclose photographs of me at any time by sending a letter to A Medical Spa at Rizzieri's Medical Director telling him or her not to disclose photographs of me to affiliates, successors, or assignees of A Medical Spa at Rizzieri. If I send a letter saying that I revoke my authorization, A Medical Spa at Rizzieri's Medical Director will not disclose any more photographs of me after he or she receives the letter. However, the Medical Director will not need to return any photographs disclosed prior to his or her receipt of the letter.

I understand that once my photographs have been disclosed to A Medical Spa at Rizzieri, affiliates, successors and assignees the photographs will no longer be protected by federal privacy laws. However, A Medical Spa at Rizzieri's affiliates, successors, and assignees will not use the photographs except as permitted on this authorization form. I understand that I will be given a signed copy of this form.

I hereby release A Medical Spa at Rizzieri, its affiliates, successors, and assignees from any claim demand, cause, action, or proceeding of whatever nature arising out of publication and distribution of the said photographs in accordance with the terms of this authorization.

Print name:_____ Signature:_____ Date:_____

A Medical Spa AT RIZZIERI

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The Practice reserves the right to change the privacy as allowed by law.
- The Patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The Patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The Practice may condition receipt of treatment upon execution of this consent.

Messages/Alerts/Requests/Appointment Confirmation/Other (not identified) from this practice and or Rizzieri Salons, Spas, Schools to yourself may/are done via telephone (home/cell), email, text, and any other form of communication deemed necessary (not specifically described herewith). **I understand that I am permitted to revoke this method of communication to share my health data at any time and can do so by submitting a request in writing to:**

A Medical Spa @ Rizzieri and Rizzieri Salons, Spas, School
307 Fellowship Road – Suite 307
Mt. Laurel, New Jersey 08054
c/o Andrea Gambino

This consent was signed by _____ (Please Print)

Signature: _____ Date: _____