CENTRAL COAST
MEDICAL AESTHETICS
*Paso Robles*

## Patient Information

**Today's Date: ____/____/____**

Patient Name:_____Sex: M_____F_____

Home Address:_____ City:_____ Zip:_____

Home Phone:_____Cell Phone:_____ Single:_____Married:_____

Birth Date:_____/_____/_____Email Address:_____@_____

How did you hear about us? _____ Referred by: _____

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Spouse's Name:_____ Sex: M_____ F_____

Home Address (if different from above)_____ City:_____ Zip:_____

Home Phone (if different from above)_____ Cell Phone:_____

Employer:_____ Work Phone:_____

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Nearest relative not living with you:_____

Home Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Relationship:_____

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Emergency Contact #1:_____

Home Phone:_____ Cell Phone:_____

Emergency Contact #2:_____

Home Phone:_____Cell Phone:_____

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**Signature:**_____ **Date:**_____

# MEDICAL HISTORY

Patient's Name: _____ Today's Date: _____

Physician's Name: _____ Phone #: _____

Date of last physical Exam: _____

**Have you been admitted to a hospital or needed emergency care during the past two years?**

If yes, please explain: _____

**Please list any medications, drugs or pills you are taking. Include dosage amounts and times that you take them:**

_____

**Please list any medications or substances you have had an allergic reaction to or reacted adversely to:**

_____

**Please check the following conditions you have or have had**

| Yes | No | Conditions | Yes | No | Conditions |
|---|---|---|---|---|---|
| ___ | ___ | Alcoholism | ___ | ___ | Head Injury |
| ___ | ___ | Anemia | ___ | ___ | Hearing Impaired |
| ___ | ___ | Arthritis | ___ | ___ | Heart Disease |
| ___ | ___ | Artificial Heart Valve | ___ | ___ | Heart Murmur |
| ___ | ___ | Artificial Joints | ___ | ___ | High Blood Pressure |
| ___ | ___ | Blind | ___ | ___ | Latex Allergy |
| ___ | ___ | Blood Thinners | ___ | ___ | Liver Disease |
| ___ | ___ | Cold Sores / Fever Blisters | ___ | ___ | Nervous Disorders |
| ___ | ___ | Developmentally Disabled | ___ | ___ | Respiratory Problems |
| ___ | ___ | Excessive Bleeding | ___ | ___ | Sinus Problems |
| ___ | ___ | Fainting or Dizziness | ___ | ___ | Tuberculosis |
| ___ | ___ | Glaucoma | ___ | ___ | Ulcers |
| ___ | ___ | Hay Fever | ___ | ___ | Venereal Disease |
| ___ | ___ | HIV or Aids | ___ | ___ | Asthma |
| ___ | ___ | Angina / Chest Pains | ___ | ___ | Cancer |
| ___ | ___ | Kidney Disease | ___ | ___ | Epilepsy or Seizures |
| ___ | ___ | Are you Diabetic? | ___ | ___ | Are you allergic to Soy |

____ ____ Do you use Tobacco

Smoke? _____ Packs per day _____ For how many years _____

Smokeless? _____ Cans per day _____ For how many years _____

____ ____ Do you drink alcohol? How many per day ____ How many per week ____

____ ____ Are you a recovering drug addict?

____ ____ Recreational Drug Use What do you use _____

____ ____ Do you have Hepatitis What type _____

____ ____ Are you pregnant Due date: _____ O.B. Name: _____

____ ____ Have you had surgery. If so please explain: _____

**Please put a check mark in front of the items that relate to you.**

| | | | |
|---|---|---|---|
| ☐ Skin Pigmentation issues | ☐ Skin Flushing | ☐ Redness of Skin | ☐ Capillaries |
| ☐ Skin exfoliation | ☐ Blackheads | ☐ Acne (cystic) | ☐ Acne scars |
| ☐ Wrinkles | ☐ Rough skin | ☐ Large pores | ☐ Sun spots |

**Tanning** (last 6 weeks)

| | | | |
|---|---|---|---|
| ☐ Sun exposure | ☐ Tanning bed | ☐ Tanning products | ☐ None |

**Skin Conditions**

| | | | |
|---|---|---|---|
| ☐ Skin infection | ☐ Easy bruising | ☐ Permanent Make up | |
| ☐ Sun sensitivity | ☐ Tattoos | ☐ Eczema | ☐ None |
| ☐ Poor healing | ☐ Keloids / Scaring | ☐ Skin Cancer | |

**Specific Medications:** ☐ Retin-A (last 2 weeks) ☐ Accutane (last 6 months)

**Sensitivity to:** ☐ Hydroquinone (skin lighting agents) ☐ Glycolic acid (skin cleanser)
☐ Lidocaine (anesthetics) ☐ None
☐ Other: _____

**How often do you exercise?** ☐ 5-7 days/week ☐ 3-4 days/week ☐ 1-2 days/week ☐ None
Duration of workouts ☐ 1 hour or more ☐ 30 min.-1 hour ☐ 30 minutes or less

Any other medical conditions you may have that are not listed above: _____

_____

To the best of my knowledge, all of the preceding answers and information are true and correct.

_____ _____

**Signature of Patient, Parent or Guardian** **Date**

**OFFICE USE ONLY**

# CANCELLATION POLICY
# REFUND POLICY
# PRIVACY POLICY

Dear Patient,
Thank you for choosing **Central Coast Medical Aesthetics** Please carefully read and review all of the items below as the information pertains to our refund, cancellation and privacy policy:

**Cancellation of Appointments and No Shows**

**1.** While we make every effort to accommodate our clients, we regret that without at least **48 hour** cancellation notice to reschedule or cancel your appointment there will be a **$50.00 fee.** We understand there are some circumstances beyond your control; we will take this into consideration. **Patient Initials**_____

2. **If we do not have a valid card on file and you fail to meet our** 48 hour **cancellation notice, we will deduct a service from one of your packages as an alternative to the $50.00 fee.** **Patient Initials**_____
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**3.** A credit card is needed at time of booking an appointment. **Central Coast Medial Aesthetics** will charge your credit card a **$50.00 fee** if you fail to meet our cancellation policy. This also applies to appointments made the same day and of your appointment. **Patient Initials**_____

**4.** If you are more than 15 minutes late, we will unfortunately need to reschedule your appointment, which is subject to a **$50 fee.** **Patient Initials**_____

**5.** There will be a **$25.00 fee** for all returned checks. **Patient Initials**_____

**6.** No refunds will be issued, however we are happy to transfer credit to any other service or product of your choice. **Patient Initials**_____

**7.** Patients receiving **Laser Hair Removal** must be shaved in the treatment area prior to your appointment. Failure to do so may result in a need to reschedule your appointment due to the fact this time was reserved for your procedure and will result in making other clients after you wait for their appointment. **Patient Initials**_____

**8. Patients receiving specific Laser Treatments or Fillers (i.e. All Dermal Fillers) must arrive 30 minutes prior to the appointment time for numbing cream application. Failure to do so may result in a need to reschedule your appointment due to the fact this time was reserved for your procedure and will result in making other clients after you wait for their appointment.**

**Patient Initials**_____

**9.** Your privacy is important to us. **Central Coast Medical Aesthetics** does not share any patient information or financial documents with outside parties. **Patient Initials**_____

**How to Cancel Your Appointment**

To cancel appointments call us at **(805)238-6330.** You may leave a detailed message on the voicemail.

## WE REQUIRE A CREDIT CARD TO HAVE ON FILE.

IF YOU CHOOSE NOT TO LEAVE A CREDIT CARD ON FILE OR DO NOT HAVE A CREDIT CARD YOU WILL NEED TO PAY FOR SERVICES IN FULL PRIOR TO YOUR APPOINTMENT.

**Visa [ ] MasterCard [ ] American Express [ ] Discover [ ] Care Credit [ ]**

**Credit Card #** _____ **Expiration Date** _____/_____ **CVV #** _____

My signature attests to the fact that I understand and agree to the information contained within.

**Print Name** _____ **Date** _____

**Signature** _____ **Date** _____

# CALIFORNIA ARBITRATION AGREEMENT

**PATIENT NAME:** _____

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must Be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by Advanced Body and Laser ("Retailer") including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence-giving rise to any claim. This agreement is intended to bind the patient and "Retailer" and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by working or associated with or serving as back-up for "Retailer", including those working at the "Retailer's" clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the "Retailer", and/or the "Retailer's" associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the "Retailer" within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) **patient should initial here** _____. Effective as the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Arbitration Agreement.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

**This Arbitration Agreement is dated on this day** _____ **of** _____, _____ **by both parties.**

**CCMA of Paso Robles**("Retailer") **By:** _____ (Retailer's Signature")

**Patient's Name** **By:** _____ (Patient's Signature")