



MEDICAL HISTORY

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female _____ Male _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas or condition would you like treated? _____

Please answer all of the following questions

1. Do you have **ANY** current or chronic medical illnesses?

YES NO
☐ ☐

Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.

Please List: _____

2. Do you have **ANY** current or chronic skin conditions?

☐ ☐

Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

Please List: _____

3. Are you currently under a doctor's care? If so, for what reason?

☐ ☐

4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis?

☐ ☐

Please List: _____

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?

☐ ☐

Please List: _____



MEDICAL HISTORY, CONTINUED

		YES	NO
6.	Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
7.	Do you have ANY allergies to medications, foods, latex or other substances?	☐	☐
	Please List: _____		
8.	(For women) are you or could you be pregnant?	☐	☐
9.	(For women) are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?	☐	☐
10.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
11.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
12.	Do you have a history of light induced seizures?	☐	☐
13.	Do you have any open sores or lesions?	☐	☐
14.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
15.	In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: _____	☐	☐

16.	In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxyacid acid products; exfoliating or resurfacing products or treatments? Please List product name and date last used: _____	☐	☐

17.	Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.? If yes, please list locations on or in the body and dates: _____	☐	☐

18.	Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? If yes, please list locations on or in the body and dates: _____	☐	☐

19.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
20.	Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?	☐	☐
21.	Have you ever had a problem when having your blood drawn?	☐	☐
22.	Do you think that you sweat more than normal or are an excessive sweater?	☐	☐
23.	Do you have a history of fainting or passing out?	☐	☐
24.	Do you consider yourself to have an anxious or nervous personality?	☐	☐
25.	Have you been diagnosed with an anxiety disorder?	☐	☐
26.	Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4 weeks?	☐	☐

Signature: _____ Date: _____

A. ROY HERON, JR., M.D.: Patient Consent Form

The Department of Health and Human Service has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for use and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment of health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You must refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Patient Name (Please Print)

Signature _____ Date _____

COMPLIANCE NOTIFICATION TO OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and costing money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance to the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read and understand the Notice.

Patient Name (Please Print)

Signature _____

Date



Marketing Authorization and Use of Photographs

According to federal law we must ask for your permission to send to you via email or regular mail information regarding our practice such as products we sell, promotions we have or any services the practice offers (i.e., office promotions that include special discounts). Our office **DOES NOT SELL** our patients names.

This authorization is effective until revoked in writing.

I voluntarily sign this authorization, and I understand that my health care will not be affected if I do not sign this form. I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Heron Med Spa in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by Heron Med Spa in reliance on this authorization before Heron Med Spa receives my request for revocation or modification. I must sign my written request and send it to:

Privacy Contact

Heron Med Spa, 321 South Patrick Street, Alexandria, VA 22314

I DO _____ I DO NOT _____

Authorize Heron Med Spa to use and disclose my Protected Health Information (PHI) to mail to me any information regarding the products, services or promotions the practice offers.

I DO _____ I DO NOT _____

Authorize Heron Med Spa services or promotions the practice offers.

Patient Signature

Date

Email Address (Please Print)



SCULPSURE INFORMED CONSENT FORM

The SculpSure® delivers laser energy to heat the deep layer of fat. The heat that is created damages the fat cells. The damaged fat cells are then eliminated by the body through your lymphatic system.

During the laser delivery the applicators cool the skin throughout the entire treatment. The cooling protects your skin while the energy heats your fat layer. When the treatment begins, it will feel warm, and over time the heat sensation will increase to short periods of intense deep heat. You may also experience some cramping, tingling, prickling or squeezing sensations deep in the fat layer. These sensations are normal and expected. These sensations indicate that the laser is effectively targeting and damaging the fat layer.

- The SculpSure is eye safe. There is no need to wear protective eyewear.
- Your skin may be slightly pink to red immediately after treatment. This may last for a few hours.
- Following the SculpSure treatment you may experience swelling and tenderness that typically lasts for approximately 2 weeks, but may last longer. You may also experience tissue firmness or nodules. Nodules can last for days to several months, depending on the size of the nodule. This side effect will resolve on its own.
- The treated areas should be massaged two (2) times a day for five to ten (5-10) minutes. There are no lifestyle restrictions following your SculpSure treatment. It is recommended to increase your water intake after treatment.
- You may use ice packs or Tylenol according to package instructions to help ease tenderness.
- I have been thoroughly and completely advised regarding the end point of the procedure. I understand that the practice of medicine is not an exact science and no results have been guaranteed. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized.
- There is no guarantee that the expected or anticipated results will be achieved.

I have been informed that firmness, hardness, nodules, redness, tenderness, swelling, pain, and bruising, are the most common side effects. Other less common side effects which can occur are itching, skin contour irregularities, dimpling, hyperpigmentation/hypopigmentation, asymmetry, necrosis, changes in skin laxity, numbness, blister or burn. Rare occurrences of fainting or dizziness have been noted during and/or after the treatment. ☐ Yes ☐ No

I confirm that I have not had sun exposure within the last 7 days. ☐ Yes ☐ No

I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly for such stated purposes without my permission. ☐ Yes ☐ No

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction. ☐ Yes ☐ No

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered. Consent for treatment of _____

Client: _____ Date _____

Witness: _____ Date _____
