Personal History

Name: ____ Today's date:______________

Birthdate (mm/dd/yy): _______________ Age: _______ (if under 18 need parental or legal guardian consent)

Occupation:__________________________

Home Address:____

City: ___________________ State: _____ Zip: ___________

Home Phone: _________________________ Cell Phone: ________________________________

Email address: ______________________________ (PLEASE PRINT LEGIBLY)

Best way to contact me: ____ Home ____Cell _____ Email

Emergency Contact Name and Phone: ____

How did you hear about Inkfree, MD (please check all that apply):

___ Web Search ___ Living Social ___ Drive by

___ Facebook/Twitter ___ Friend/Referral ____________________ Other

___ Groupon ___ Radio

Assignment

I, the undersigned, understand that I am financially responsible for all charges. I understand that insurance carriers do not cover these services.

Signature: ____ Date: _______________

Medical History

Providing us with accurate and up to date information is critical and may affect what procedure we may recommend or undertake. There exists a risk if our staff is not aware of the general health and medical background of a patient.

Skin Type

Which of the following best describes your skin type? (please circle one number)

I. Always burns, never tans
II. Always burns, sometimes tans
III. Sometimes burns, always tans
IV. Rarely burns, always tans
V. Brown, moderately pigmented skin
VI. Black skin

Do you regularly use tanning salons, spray (bottle tans) or sun bathe? ____ Yes ____ No Last time _________________

Reason for your visit:

___ Laser Tattoo Removal ___ Laser Spider Vein Removal

___ Laser Hair Removal ___ Laser Toenail Fungus Removal

___ Laser Sun/Age/Liver Spot Removal ___ Other ____

Where is/are your tattoo(s)/unwanted hair/spots/spider veins? ____

If we are treating a tattoo, how old is it/are they? ____

Is it homemade or professional? :____

Past Medical History

Do you have any of the following medical conditions? (please check all that apply)

___ Cancer ___ Frequent cold sores ___ High blood pressure

___ Diabetes ___ HIV/AIDS ___ Seizure disorder

___ Skin diseases ___ Hepatitis ___ Blood clotting abnormality

Do you have any medical problems or health concerns? (please list all) _____________________________

____

Are you currently taking any medications? (please list all) _______________________________________

____

Do you have allergies to any medications, foods, or latex products? _______________________________

What topical creams are you currently using? ___ Retin-A ___ Others (please list all)

____

Have you ever used Accutane (prescribed for acne)? ___ Yes If yes, when did you last use it?

____

Have you ever had any laser treatments or chemical peels before? (please describe all) ______________

____

Have you had any surgeries before? (please list all) ____

____

Do you currently have a sunburn in the area to be treated? ___ Yes ___ No

Do you form thick or raised scars known as keloids from cuts or burns? ___ Yes ___ No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma (i.e. a cut or burn): ___ Yes ___ No

If yes, please describe: ____

For our female patients

Are you pregnant or trying to become pregnant? ___ Yes ___ No

Are you breastfeeding? ___ Yes ___ No

Is there anything else about your health history you feel it is important for us to know? _____________

____

Patient Consent

I certify that the preceding medical, personal and skin history are true and correct. I am aware that it is my responsibility to inform Inkfree, MD of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: ____ Date: _____________________

Parent/Legal Guardian Consent

Signature: ____ Date: _____________________

Witness

Signature: ____Date: _____________________

<u>Informed Consent for Treatment</u>

I, ____consent and authorize Inkfree, MD and members of its medical staff to perform laser skin treatments on me using the Alex Tri-Vantage or the Apogee Elite laser.

The laser is a device that produces an intense but gentle burst of light. This light is absorbed by and causes selective heating of certain cells in your unwanted tattoo or lesions. Tattoos or lesions most commonly fade slowly over time as these destroyed cells are eliminated by normal body processes.

My eyes will be covered with laser specific safety eyewear or an opaque material to protect them from the intense light. My eyes will be closed and I will not attempt to remove the eye protection during the treatment.

I have been informed of the following possible risks and complications of this procedure including but not limited to:

Purpura (red-purple discoloration, bruising)

Itching (hive-like response which lasts 2-3 hours to 2-3 days)

Herpes simplex virus activation

Infection

Burns, blisters, scabbing, crusting, skin color and /or textural changes

Hyperpigmentation (darkening of the skin; transient or long term)

Hypopigmentation (lightening of the skin; transient, long term or possibly permanent)

Scarring (rare, possibly permanent)

I understand that complete clearing may not be possible and will depend upon the type, age and color of the tattoo or lesion. Multiple treatments may be needed for the best results.

Other methods of treating this condition have been discussed with me, such that I may assess the risks and benefits of these alternative treatment methods.

Anesthesia is usually not necessary. My provider or I may elect to use a form of topical anesthesia to reduce any discomfort during the procedure. If I decide to use a topical anesthetic cream containing lidocaine, I have received and reviewed a copy of the Instructions for Use sheet for the topical anesthesia and understand the risks of improper or over use of this anesthetic. A cooling device may be used during the procedure to decrease discomfort and protect the skin. All anesthesia options and risks will be discussed with me in advance.

I understand that immediately following the laser treatment redness, swelling, discomfort, bruising and discoloration may develop at the treatment site. I understand that any discoloration may last 7-14 days and swelling should resolve within several days. Discomfort may be treated with the application of cool compresses or topical soothing agents.

I understand the complete instructions regarding the after care of the treated area are available at www.inkfreemd.com. It is important to follow the After Care Instructions carefully to minimize the chance of incomplete healing, skin textural changes or scarring. Sun avoidance and /or use of a sunblock may be recommended. Tanning should be avoided.

_____I have provided my past and current medical history and medications.

_____I consent to the taking of photographs during the course of my laser therapy for healthcare

records.

_____I consent to using my photographs for medical education and /or marketing purposes.

My name will not be used to identify these photographs.

_____I am not pregnant (female patients).

I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the information given to me.

Contraindications to the performance of this procedure have been discussed in detail with me.

I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.

I have read and understood all information presented to me before signing this consent form.

Signed: ____ Date:________________

Parent/Legal Guardian Consent (if patient under 18 years old)

Signature: ____ Date: ________________

Witness: ____ Date:________________

Privacy Policy

I have reviewed the (HIPAA) Notice of Privacy Practices, which is located on the following two pages.

Signature: ____ Date:_________________

Privacy Policy

Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
(2) We are required to abide by the terms of this Notice currently in effect.
(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

Operations: Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol

abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without you written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.
(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.
(3) You have the right to inspect copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.
(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.
(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.
(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to:
ADAEZE OKEKE, MD 11242 FM 1960 RD WEST, SUITE 107 HOUSTON, TX. 77065