GENERATIONS
MEDICAL AESTHETICS
SKIN & LASER CENTER

12040 South Lakes Drive ▪ Suite 206 ▪ Reston, VA 20191 ▪ 703-390-9343

PATIENT REGISTRATION FORM

Name:_____ Date:_____

DOB:_____ Age:_____ Sex: M F Marital Status: S M D W Sep

Home Address:_____ City:_____ State:_____
Zip:_____ Employer:_____ State:_____

Contact Info

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Email Address (receive newsletters, event info, and specials:_____

Emergency Contact: _____ Relation:_____Phone:_____

Primary Care Physician: _____Phone: _____

Do we have permission to: Leave a message on your place of work? YES NO

Leave a message on your cell phone? YES NO Leave a message on your home phone? YES NO

Discuss your medical condition with any member of your household? YES NO

How did you learn about us?

□ Internet, Referred by:_____ □ Facebook
□ Friend, Referred by:_____ □ Doctor, Referred by:_____
□ Health Fair, Referred by:_____ □ Seminar, Referred by:_____
□ Other. Please specify:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I have received a copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

_____ _____ _____

Patient Name(please print) Parent Signature or Legal Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials: Reason:

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HEALTH HISTORY

What brings you to our office? Please be as specific: How long have you had this condition?

_____ _____

Have you had any previous treatment(s) for this condition? If "yes, How and when it was treated?

_____

Height: _____Weight: _____

	Y	N		Y	N		Y	N
AIDS or HIV positive	□	□	Gold therapy	□	□	Pneumonia	□	□
Anemia	□	□	Epilepsy	□	□	Psoriasis	□	□
Arthritis	□	□	Heat problems	□	□	Pregnant or trying	□	□
Asthma	□	□	Heart murmur	□	□	Psychiatric condition	□	□
Back Problems	□	□	Heart palpitations	□	□	Rheumatic fever	□	□
Blood clots in legs	□	□	Hepatitis	□	□	Seizures	□	□
Blood disorders	□	□	Hernia	□	□	Shortness of breath	□	□
Bleeding problems	□	□	High blood pressure	□	□	Stomach problems	□	□
Breath Problems	□	□	Histamine reactions	□	□	Stroke	□	□
Cancer	□	□	Hypersensitivity to cold	□	□	Thyroid problems	□	□
Chest pains	□	□	Irregular heart beat	□	□	Tuberculosis	□	□
Colitis	□	□	Kidney problems	□	□	Transfusion	□	□
Diabetes	□	□	Migraine headaches	□	□	Vitiligo	□	□
Ear/eye problems	□	□	Nervous breakdowns	□	□			

PAST, FAMILY, AND/OR SOCIAL HISTORY

Current medical conditions? List any hospitalizations and/or previous surgeries including dates:

_____ _____

Are you allergic to or have you ever had a reaction to any medication, drug, local anesthetic, or general anesthetic?

NO YES If so, what?_____

Are you now or have you ever taken any medications regularly (e.g. aspirin, ibuprofen, steroids, birth control, vitamins, oral acne medication, antibiotics with Tetracycline or sulfa classes, etc.)? Currently taking:_____ Previously Taken:_____

Y	N		
□	□	Do you currently smoke?	If yes, how many packs per day? ___How many years?_____
□	□	Have you ever smoked?	If yes, how many packs per day? ___How many years? _____
□	□	Do you drink alcohol?	If yes, how much? _____ How many years? _____
□	□	Have any of your relatives had skin cancer?	If yes, what is their relation to you?
□	□	Have you ever been under the care of a dermatologist?	If yes, for what?
□	□	Have you ever been on Accutane?	If yes, for how long?
□	□	Have you ever had excessive exposure to radiation?	
□	□	Have you ever had excessive exposure to the sun?	
□	□	Do you have problems with excessive scarring or keloid formation after being cut?	
□	□	Is your general health good?	
□	□	Have you ever had psychiatric problems, a nervous breakdown, or been under the care of a psychiatrist, psychologist, or mental health counselor?	

_____ _____ _____

Patient Name (please print) Parent Signature or Legal Date

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FINANCIAL POLICIES

Complimentary Consultation
There is no fee for a consultation. At that time, the provider will discuss treatment options and associated costs. If there is time and you choose to receive treatment, payment will be owed at the end of your treatment.

Payment Methods
We accept payment by cash, check, Visa, MasterCard, American Express and Care Credit. Payment is due at the time of service. We will not bill for services. For more information about payment with no interest for 6 months, please see the section on Care Credit Financing below.

Care Credit Financing
We are pleased to offer our patients the CareCredit card, North America's leading patient payment program. The CareCredit card is just as easy to use as a regular credit card, but it's designed specifically for your health and beauty needs. We offer 6 month no interest payment plans from Care Credit. You can even use your CareCredit card over and over for follow-up appointments.

Returned Check Fee
There is a service charge of $25.00 for each check returned to our office for insufficient funds or any other reason. If this should happen, your account may be subject to cash and credit card only.

Appointment Cancelation/No-Show Fees
Since we are often unable to fill appointments canceled with little or no notice, a $75.00 cancelation fee will be incurred for no-show appointments or appointments that are canceled with less than 24 hours' notice.

Package Pricing & Payment
Occasionally, we may offer package specials. Payment for the entire package is due at the time of the first treatment. We will not bill per treatment.

CoolSculpting
Because CoolSculpting requires that we block significant amounts of time, we require full payment in advance. In the event that a client needs to reschedule, their prepaid amount will be credited towards future treatment(s).
A cancellation fee of $200 will be incurred for a no show of treatment or less than 72 hours' notice to move or charge your appointment.

I, the undersigned, have read the above and realize that all charges incurred to me or my dependents for services or products rendered by Generations Family Practice/Generations Medical Aesthetics are my responsibility. All court fees or other fees necessary to collect on this account are my responsibility.

_____	_____	_____
Patient Name(please print)	Parent Signature or Legal	Date

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Patient Name:_____ Date:_____

Photograph Consent and Release

I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after procedures. The photographs will be taken by one of the members of the Generations Medical Aesthetics medical staff. I hereby give my consent for Generations to use the photographs under one of the following circumstances.

Please initial one of the following:

_____ **Internet**: I give consent as a voluntary contribution in the interest of public education, and my consent is subject only the condition that I am not identified by name. Photographs are taken of me or parts of my body as well as details regarding the medical services that I received at Generations Medical Aesthetics can be used on the company's website in order to inform the public about cosmetic procedures.

_____ **All Media**: I give consent as a voluntary contribution in the interest of public education, and my consent is subject only the condition that I am not identified by name. Photographs are taken of me or parts of my body as well as details regarding the medical services that I received at Generations Medical Aesthetics can be used in any print or broadcast media, including, but not limited to, pamphlets, social media, and internet.

_____ **Medical Care Only**: Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Generations Medical Aesthetics. The photographs and all details regarding medical services rendered to me at Generations Medical Aesthetics will be kept confidential within my personal medical file at Generations Medical Aesthetics.

I release and discharge Generations Medical Aesthetics, any employees of Generations Medical Aesthetics, and all parties acting under their license and authority, from any claim for payment in connection with any such use or publication.

By signing this form, I acknowledge my consent as initialed above, and I further recognize that this consent form will superseded any other photographic consent forms with a date prior to the date written below. This consent may be revoked at any time by written request or by completion of a new form.

_____	_____	_____
Patient Name (please print)	Parent Signature or Legal	Date

_____	_____
Witness Signature	Date