GENERATIONS
MEDICAL AESTHETICS
SKIN & LASER CENTER

12005 Sunrise Valley Drive▪ Suite 160 ▪ Reston, VA 20191 ▪ 703-390-9343

PATIENT REGISTRATION FORM

Name: _____ Date: _____

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

Home Address:_____ City:_____ State:_____

Zip:_____ Employer:_____ State:_____

Contact Info

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

Email Address: _____ Instagram Name: _____

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 Search, Facebook, Instagram
□ Friend, Referred by: _____
□ Doctor, Referred by: _____
□ Health Fair or 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. Please scan this QR code to review the HIPAA policy:
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) Patient Signature or Legal Guardian 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:

Revised 12/3/2024

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: _____ Any reaction to prior treatment? _____

AIDS or HIV positive	Y	N	Ehlers Danlos Syndrome	Y	N	Psoriasis	Y	N
Anemia	Y	N	Epilepsy	Y	N	Pregnant or trying	Y	N
Arthritis	Y	N	Gold therapy	Y	N	Psychiatric condition	Y	N
Asthma	Y	N	Heart problems or palpitations	Y	N	Rheumatic fever	Y	N
Auto-immune Diseases	Y	N	Heart murmur	Y	N	Seizures	Y	N
Back Problems	Y	N	Hepatitis	Y	N	Shortness of breath	Y	N
Blood clots in legs	Y	N	Hernia	Y	N	Stomach problems	Y	N
Blood disorders or use of blood thinners	Y	N	High blood pressure	Y	N	Stroke	Y	N
Bleeding problems	Y	N	Histamine reactions	Y	N	Thyroid problems	Y	N
Breathing Problems	Y	N	Hypersensitivity to cold	Y	N	Tuberculosis	Y	N
Cancer	Y	N	Irregular heartbeat	Y	N	Transfusion	Y	N
Chest pains	Y	N	Kidney problems	Y	N	Vitiligo	Y	N
Colitis	Y	N	Migraine headaches	Y	N	Other skin conditions	Y	N
Diabetes	Y	N	Nervous breakdowns	Y	N	Any Metal allergy/sensitivity	Y	N
Ear/eye problems	Y	N	Pneumonia	Y	N			
Any active implanted devices such as pacemakers and defibrillators	Y	N	Neuropathic disorder such as post-herpetic neuralgia or diabetic neuropathy	Y	N	Red or Purple bumps that occur as a reaction to cold	Y	N

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: _____

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

_____ _____ _____

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FINANCIAL POLICIES

- **Complimentary Consultation**

There is no fee for a consultation. During the consultation, the provider will discuss treatment options and associated costs. If there is time and you choose to receive treatment, payment will be due at the end of your treatment. Any cancellation, with less than 24-hour notification, or no show for your appointment will require a $50 deposit to reschedule the consultation. If treatment is provided or scheduled the deposit will be applied to the final bill otherwise, no refund will be issued.

- **Payment Methods**

We accept payment by cash, check, Visa, MasterCard, American Express and CareCredit financing. Payment is due at the time of service. We will not bill for services.

- **Care Credit**

We are pleased to offer our patients the CareCredit financing, North America's leading patient payment programs. The CareCredit financing 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 and 12 months for GreenSky. You can even use your CareCredit financing over and over for follow-up appointments. There is a $50 fee for any refunds processed to CareCredit.

- **Refunds**

Refunds will be issued, depending on initial payment source, as follows: 1) paid by cash, check or credit card you may receive credit on account; 2) paid by cash or check you may be refunded by check within 15 days of date of refund, 3) paid by credit card must be refunded back to original credit card used at time of purchase even if the credit card has been closed. The credit card company will issue you a check for the funds credited back to the account.

- **Returned Check Fee**

There is a service charge of $50.00 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. Generations Medical Aesthetics will not accept checks over $500.

- **Cancellation Notice:** We kindly request a minimum of 24 hours' notice for any appointment changes or cancellations.
- **Late Cancellation Fee:** A fee of $100 will be charged for cancellations made with less than 24 hours' notice. This fee aims to compensate for the time reserved and the inconvenience caused.
- **How to Cancel:** Please contact us as soon as possible if you need to reschedule or cancel your appointment. We will only accept cancellations through phone calls, text messages, or emails. We do not accept cancellation messages through social media sources.
- **Exceptions:** We understand that emergencies happen. If you have a genuine emergency and are unable to provide the required notice, please contact us to discuss your situation. For medical reasons, a doctor's note will be required to waive the cancellation fee.
- **No-Show Policy:** In the event of a no-show (failure to appear for a scheduled appointment or more than 15 minutes late without prior notice), a fee equivalent to the full-service cost will be charged.

We appreciate your understanding and cooperation with our cancellation policy. By scheduling an appointment with our med spa, you acknowledge and agree to the terms outlined above. If you have any questions or concerns, feel free to reach out to us. Thank you for choosing our services.

- **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/Morpheus 8**

Because CoolSculpting and Morpheus 8 require that we block significant amounts of time, we require full payment in advance. If 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 change your appointment.

I also agree that I will not dispute any charges with my credit card company without first making a good faith effort to remedy the situation directly with Generations Medical Aesthetics. I authorize Generations Medical Aesthetics to send my bank any documents proving charges, waiving HIPAA privacy should I fail to follow this good faith process. I understand that Generations Medical Aesthetics will contact me at the e-mail address provided, or by phone, if there is ever an issue with my credit card information. I further understand that a fee of 7.50% may apply if charges are disputed or returned.

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 Medical Aesthetics are my responsibility. All court fees or other fees necessary to collect on this account are my responsibility.

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

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PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Patient Name: _____ Date: _____

I acknowledge that photographs will be taken of me or parts of my body before and after procedures at Generations Medical Aesthetics. These photographs will be taken by a member of the Generations Medical Aesthetics staff. I understand that these photographs are the sole property of Generations Medical Aesthetics and are intended for the purposes outlined below.

I hereby give my consent for Generations Medical Aesthetics to use these photographs under one of the following conditions:

Please initial one of the following:

_____ **Internet Use:** I give consent as a voluntary contribution in the interest of public education. My consent is subject to the condition that I am not identified by name. Photographs taken of me or parts of my body, as well as details regarding the medical services I received, may be used on Generations Medical Aesthetics' website or social media platforms to educate the public about cosmetic procedures.

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

_____ **Medical Records Use Only:** Photographs taken of me or parts of my body may be used solely for the purpose of my medical care with Generations Medical Aesthetics. These photographs and all details regarding the medical services rendered to me will remain confidential within my personal medical file.

Important Notes:

All photographs remain the intellectual property of Generations Medical Aesthetics, even if the photographs were taken by an employee or a specific nurse as part of their work.

Photographs may only be used or shared in accordance with this consent form. Unauthorized personal use, redistribution, or editing of these images by staff or employees is strictly prohibited.

Staff and employees are required to use photographs only as approved by Generations Medical Aesthetics, and must not attach their personal information, branding, or names to these images.

I release and discharge Generations Medical Aesthetics, its employees, and all parties acting under its license or authority from any claim for payment or damages related to the use of these photographs as outlined above.

By signing this form, I acknowledge my consent as initialed above. I also recognize that this consent form supersedes any prior photographic consent forms. I understand that this consent may be revoked at any time by submitting a written request or completing a new consent form.

Patient Name (Print): _____Patient Signature: _____Date: _____