North Shore Health Solutions ltd

Laser Lipo Solutions treatment PATIENT APPLICATION FORM

In order to be seen I agree to:

Fill out the following information as thoroughly as possible so we can let you know if we can accept your case. I agree to the above terms, and understand that should I NOT have the paperwork completed to the best of my ability, I may NOT be seen. I also agree and understand that should I receive a consultation on my case as outlined in this paperwork, that Dr. Martin is assessing my case on the basis of her medical license alone.

Print Name_____Signature _____

Patient Information

Today's Date:

Age__Gender: M F

Home

_____

Address/City/State/Zip: _____

_____ Email Address:

_____

Cell Phone: _____

_____

Home Phone: _____

Birth Date:_____

Marital Status: S M D W I Have a 'significant other' (circle one)

Height:_____Weight:_____Weight gain / loss in past 18 months: _____

# of children:_____Ages: _

_____ Occupation: _

_____

_____

How did you hear about our Laser Lipo Solutions etc.? _____

Please circle any that apply to you:

- Pregnant
- Trying to conceive
- Breastfeeding
- Currently doing detox/weight loss program (Explain:_____)
- Have generally sensitive skin or break out easily
- Have any known allergies: _____

List your top **three goals** in coming to our office.

1. _____

2. _____

3. _____

How has your weight/cellulite/eating habits affected your job, relationships, finances, family, or other activities? Please give examples: *(i.e. I am embarrassed to wear shorts in the summer because of my legs).*

What are you willing to do to achieve these goals?

What have you done in the past to lose weight, detox, or get rid of cellulite? Outcome?

Please list anything else we should know that would help us assess your case:

Patient's Statement of Privacy Rights

As a patient of North Shore Health Solutions, you have a right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compare with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.) As per allowance by HIPAA the charge is not to exceed $20.00 handling charge for processing the request for copies and a .75 cents per page for the first 25 pages, .50 cents per page 26-50 and .25 cents per page for all pages in excess of 50.
4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request.)
5. While the doctor has the right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he/she shall supply you with written notification of such disagreement.
6. The doctor has a right to rebuttal to the patient's disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.
7. You have the right to specify how access to your health information is restricted and from whom.
8. You have the right to indicate the method and/ or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
9. All covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPPA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust" under applicable Business Associate Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
10. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization.
11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
12. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPPA in establishing that standard.
13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
14. You have the right to contact the Department of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with question or to file a complaint at, Toll Free: 1-877-696-6775 or E-mail: www.hhs/gov/ocr

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with law, and have read and understand my rights to privacy and security of Personal Health Information, as a patient of this practice.

Patient Name Date

Consent to Receive a Laser Lipo Solutions treatment

Date: **Client's Name (printed):**_____

The above named person has requested services for a Laser Lipo Solutions treatment.
Because these treatments stimulate lymphatic circulation and are detoxifying in nature, we require a statement to ensure that there are no known medical contraindications before proceeding with the Laser Lipo treatment.
The following are known contraindications to the Laser Lipo Solutions treatment:

- Pregnant or may be pregnant
- Nursing
- Heart Conditions or taking certain medications (i.e., blood thinners)
- Epilepsy
- Currently undergoing Chemotherapy
- Known adverse reactions to niacin (creams we use are niacin-based)

I understand that I may experience a slight flush of the skin, a warming sensation, or may develop an allergic reaction (such as a rash). I have completed or have been given the option of completing a patch test before choosing to receive a Laser Lipo Solutions treatment. If I experience any pain or discomfort during the session, I will immediately inform the individual(s) performing the treatment so that the products and/or technique may be adjusted to my level of comfort.

Because the Laser Lipo Solutions treatment should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the person(s) performing the wrap updated as to any changes in my medical profile before the session and understand that there shall be no accountability on the individual(s) part should I fail to do so.

By signing this form, I give North Shore Health Solutions consent to perform the wrap and release them from all liability.
Further, I agree to the above statements and agree that there are no contradictions.

Client Signature_____Date _____