



CONFIDENTIAL INTAKE FORM

First Name: _____ Last Name: _____

DOB: ____/____/____ Age: _____ Sex: Male Female

Street Address: _____ City: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____

Email Address: _____

Occupation: _____ Work Phone: _____

Primary Care Physician: _____ Phone Number: _____

Referral Information We would appreciate learning how you heard about us? Check one, please:

- Another medical provider? If so, please specify who: _____
- Family member or friend who is a patient of this practice (please specify): _____
- Google Yelp! Internet Other (please specify): _____

In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The Health Care Consumer (HCC) – Health Care Provider (HCP) relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false information may seriously and adversely affect your health.

Emergency Contact:

Name:	Address:
Home Ph:()	Mobile: () Email:

Chief Complaint/s (Please list in order of importance to you)

Medication Name	Dose	Last Taken

Please list all of the medication you are taking. Include over the counter medications, herbs, and vitamins.

Medication Name	Dose	Last Taken

Surgical/Trauma History

Surgery or Procedure	Date of Procedure	Name of Provider

Please list and describe any allergic reaction you have had to food, medication or insect stings

Surgery or Procedure	Date of Procedure	Name of Provider

Have you traveled in the past one year? Yes No

Travel destinations: INSIDE/OUTSIDE the United States	Time spent at this destination

Vaccination History: Please check if you had the following vaccinations and indicate the date/s.

Travel destinations: INSIDE/OUTSIDE the United States					
<input type="radio"/> Influenza	<input type="radio"/> Pneumonia	<input type="radio"/> Tetanus	<input type="radio"/> BCG	<input type="radio"/> Varicella	<input type="radio"/> HPV (Gardasil)

Have you had cold sore breakouts (oral herpes) or Acne in the past year? Yes No

Have you been using Retin-A, Anticoagulants, or Accutane in the last year? Yes No How long: _____

Have you ever had Botox/Dysport/Xeomin for the treatment of fine lines/wrinkles, Migraine headache or Hyperhidrosis (Excessive sweating)? Yes No Please specify: _____ When: _____

Area/s treated: _____ What was the outcome: _____

Have you ever had Fillers such as Juvederm, Juvederm voluma, Radiesse, Restylane or any other form of fillers not mentioned here? Yes No Please specify: _____ When? _____

Area/s treated? _____ What was the outcome: _____

Have you ever had Sclerotherapy, Laser Vein treatment, Laser skin resurfacing, Laser skin tightening, Laser hair removal, IPL, Laser tattoo removal, or any other laser treatment before? Yes No Please specify: _____

What area/s treated? _____ When? _____ What was the outcome: _____

Have you ever had Body/Facial contouring, Cellulite treatment, Non-surgical/surgical neck/facelift with Reaction, Radio Frequency or any other type body/face/cellulite treatment? Yes No Please specify: _____

When: _____ Area/s treated: _____ What was the outcome: _____

Have you ever had Glutathione/Vitamin C injections or any other skin lightening treatment/s? Yes No If yes, please specify: _____ When: _____

Area/s treated: _____ What was the outcome: _____

Have you ever had Medical Facials/ Microdermabrasion/Serum infusion/LED/Chemical peels? Yes No

Please specify: _____ When? _____

What area/s was treated: _____ What was the outcome: _____

Weight History:

When did you first become overweight? Your age then:	Year:
What do you think is the cause of your weight problem?	
Your weight goal:	Your current weight : Your Height:

What was your highest weight?	What was your lowest weight?
Have you ever stayed the same weight for 10 years or more? <input type="radio"/> Yes <input type="radio"/> No	
Have you attempted to lose weight before? <input type="radio"/> Yes <input type="radio"/> No	Most Lbs lost? # of years ago:
Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture...) and describe the results:	
Do you exercise? <input type="radio"/> Yes <input type="radio"/> No If yes, describe the type of exercise and how often:	

Present/Past Medical History

Adrenal Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heart Rhythm	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kyphosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amyotrophic Lateral Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anorexia or Bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Failure or Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arteriovenous Malformations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mania	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Myocardial Infraction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Narcolepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Obstructive Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebrovascular Accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodic Limb Movement Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Claudication	<input type="checkbox"/> Yes <input type="checkbox"/> No	Perphieral Artery Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clotting Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pituitary Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary Heart Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polycystic Ovarian Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Artery Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Restless Leg Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eclampsia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sarcoidosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Endometriosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scleroderma	<input type="checkbox"/> Yes <input type="checkbox"/> No
End Stage Renal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Erectile Dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gallstones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sjogren	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastritis or Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Disorder (Acne, Psoriasis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
GERD (reflux)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thalassemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombocytopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart or Valve Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thromophillia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemochromatosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, have you been treated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary retention or urgency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vasculitits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypotension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Visual defects	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypothyroidism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vocal cord dysfunction/paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
IBS	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Review of Systems: Have you experienced any of the following symptoms?

Constitutional		Genitourinary	
Weight Loss or Gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appetite changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Menstrual changes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue, impairs daily function	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinating that is painful or difficult	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Erection problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

Shakes/sweats from lack of drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal discharge or bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes		Musculoskeletal	
Eye pain or drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken bones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain or swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry, irritated eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle aches	<input type="checkbox"/> Yes <input type="checkbox"/> No
ENT/Mouth		Muscle weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear pain or drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent sinus infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin/Breasts	
Hearing changes or loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Masses or lumps	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nosebleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nipple discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rashes, ulcers, cold sores, acne	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory		Neurological	
Blood in your sputum	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest tightness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Coughing or choking with swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough lasting >1, productive or not	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive daytime sleepiness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Extremity pain or burning sensations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheezing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain with inhalation/coughing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness or tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular		Difficult falling asleep/staying asleep	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chest pain or heaviness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocrinologic	
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hair loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting or near fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of feet or legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Increased thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath lying flat in bed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heat or cold intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gastrointestinal		Heme/Lymph	
Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding from gums or nose	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in your stool	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained bruising	<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea or food intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen, painful lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heartburn or indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergy/Immune	
Vomiting or nausea lasting for >1 day	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watery eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swallowing difficulty	<input type="checkbox"/> Yes <input type="checkbox"/> No	Runny nose	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psych		Food intolerance	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety without clear explanation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent skin sores	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sadness lasting for day or weeks	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hearing Voices	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Thoughts of hurting yourself	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Female Patients Only

	Response	Description
Are you are pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you breastfeeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever used hormone replacement therapy? If yes, how long?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Please note that we require a credit card in order to reserve your initial appointment time. This credit card will only be charged upon missing your appointment, failure to cancel or change your appointment without at least 48 hours' notice.

Patient Signature:		Date:
Credit Card Number:	CVV:	Expiration Date:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by provided by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Patient enters into this contract are giving up their constitutional right to have such dispute decided in a court of law before jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties (LaViva M.D. Medical Corp. DBA: vivaMD and Patient) that this agreement shall cover all claims or controversies whether in tort, contract or otherwise and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, , medical group or association, their partners, associates, associations, corporations, partnership, employees (regular and in training), agents, clinics, and/or providers (here in after collectively referred to as “Physician”) to a patient, including any spouse or heirs of the patient and any children, whether born or unborn at the of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and mother’s expected child or children.

Filing by vivaMD physician and employee/s (regular or in training) of any action in any court to collect any fee from the patient shall not wave the compel arbitration of any malpractice claim. However, following the assertion of any claim against vivaMD (Physician/s, Nurses, Employee/s (regular or in training), any fee dispute whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail postage prepaid to all parties describing the claim against vivaMD (Physician/s, Nurses, Employees (Regular or in training), the amount of damage sought, the names, addresses, telephone number/s, email address of the patient and)If applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence and the arbitration shall be governed pursuant to Code of Civil Procedure 1280-1295 and the Federal Arbitration Act (9 U.S.C. 1-4). The parties shall bear their own costs, fees and expenses along with pro rata share of the neutral arbitrator’s fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by vivaMD (Physician/s, Employee/s (Regular and in training) not only after the date is signed (including, but not limited to emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may not be revoked by me-the patient and will govern all medical services received by the patient

Article 6: Severability Provision: In the event any provision(s) of this agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there form and remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement per request.

Notice: By signing this contract I agree to have any issue of Medical Malpractice decided by neutral arbitration and I’m giving up my right to have a jury or court trial.

Print Name: _____

Date: _____

Signature _____

CANCELLATION/BILLING/REFUND/EXCHANGE POLICIES

Our goal is to provide quality medical care in a timely manner. This policy enables us to better utilize available appointments for our patients in need of treatment/medical care. This is how we can best serve the needs of our patients.

If it is necessary to cancel or reschedule your appointment, we require that you call us 24 hours in advance. Credit card is required to hold an appointment.

Credit Card #: _____ Exp. Date: _____ Code: _____

Late Cancellation and No Shows:

Thank you for selecting vivaMD Medical Spa & Weight Management for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements was made.

All appointments including complimentary consultations and follow-ups canceled with less than 24 hours' notice will result in a charge. This also applies to appointments made the same day and appointments scheduled within 24 hours of appointment time. Late cancellation will be considered "No Show" and you will be held accountable for the following: \$150 charge or 50% of treatment session or loss of a session from a purchased package.

How to Cancel Your Appointment

To cancel appointments please call us at (510) 742-5795. If you do not reach a staff member you may leave a brief message on the voicemail. **You may NOT cancel via e-mail.**

I agree that should this account be referred to any agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

vivaMD Medical Spa & Weight Management return/refund or exchange policy is that **ALL SALES ARE FINAL.**

I have read and understand all of the above and have agreed to these statements. My signature attests to the fact that I understand and agree to the information contained within.

Print Name: _____ Date: _____

Signature: _____

PHOTOGRAPHIC/EMAIL/TEXT AUTHORIZATION

I, _____, (please check one of the following:

A. **authorize** vivaMD Medical Spa to text/email/take photographs, slides or videotapes of me or parts of my body showing before and after results of procedure(s) for the office use only.

B. **authorize or** **do not authorize** vivaMD Medical Spa & Weight Management the use of these images, without compensation to me, to be used in office seminars, on websites owned by or operated on behalf of vivaMD for prospective patients, in print advertisements, medical presentation, articles, and on television. (This acknowledgement does not pertain to photographs, slides, or videotapes required for medical charts and/or records.) I further agree for vivaMD to send emails/texts/phone calls regarding any vivaMD matters (i.e. appointment reminders, etc.).

I understand that:

If my answer to question 2 is yes, then I understand and agree to the following:

1. Such photographs, slides or videotapes may be published by vivaMD in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about the procedure/s. I understand that such uses may also include marketing on the behalf of vivaMD and vivaMD may receive direct or indirect remuneration.
2. I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides or videotapes may display features that identify me.
3. I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to the office of vivaMD. A revocation shall not affect any release of information made prior to revocation in reliance upon this authorization.
4. I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from vivaMD.
5. The information disclosed under this Authorization, or some portion thereof, is protected by state law and/or the federal Health Information Portability and Accountability Act of 1996 ("HIPAA"). Any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by applicable federal and/or state confidentiality rules.
6. A copy of this Authorization is valid as the original. I may inspect or copy information to be used or disclosed under this authorization, as provided by federal and/or state law.

I release and discharge vivaMD and representative from all photographic liability, including photographic liability for negligence, that in any way arises out of: any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and any claim that I may have had relating to such use and disclosure of those photographs, slides or video tapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

Patient is a minor, _____ years of age, and we, the undersigned, are the parents or guardian of the patient and do hereby consent for the patient.

This Authorization is made as a voluntary contribution in the interest of public education and I certify that I have read this Authorization and Release carefully and fully understand its terms.

Print Name: _____

Date: _____

Signature: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1990 (HIPPA).

vivaMD Medical Spa & Weight Management commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and court proceedings in response to a court or administrative order.
3. If required by law enforcement officer.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and nation security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement officials.
8. For Workers Compensation and similar programs.

Your right regarding your health information:

1. Communication: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask the way we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy to the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to vivaMD. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this Notice: You are entitled a copy of Notice of Privacy Practices. You may ask us to give you a copy to this notice at nay time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact vivaMD for further information. All complaint must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other issues and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact vivaMD for further information.

I hereby acknowledge that I have been presented with a copy of this Notice of Privacy.

Name: _____

Date: _____

Signature: _____

REACTION TREATMEN INFORMED CONSENT

Exclusion Criteria from treatment (Contraindications): Check any box that applies to you:

- Cardiac pacemaker, defibrillator, or other implanted electronic/metallic device
- Use of drugs that influence the immune system
- Any endocrine disorder, such as diabetes
- Uncontrolled thyroid disease
- Use of blood thinning medication (anticoagulants)
- History of deep vein thrombosis in the treatment area*
- Any active skin disease in the treatment area (such as herpes, eczema, rash)
- Extra dry or sensitive skin
- Sunburns in the treatment area
- Suffering from Keloid scars or impaired wound healing
- Tattoo or permanent makeup in the treatment area
- Use of Accutane/Roaccutane/Isotretinoin/ Amnesteem/Claravis/Sotret within the past 6 months
- Any aesthetic or medical surgery in the treatment area in the past 3 months
- Breast-feeding in the past 3 months
- Any synthetic filler procedure (i.e. silicon) in the treatment area
- Botox injections in the past 2 weeks
- Deep chemical peel/laser peel in the past 6 months
- For patients with chronic herpes simplex virus infections, pretreatment with antiviral medications should be initiated, especially when lesions appear in the site to be treated. Antiviral treatment typically begins 1 day prior to treatment and continues for a total of 5-7 days.

I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. I confirm that I have received all necessary information and vivaMD Medical Spa & Weight Management's Medical staff has satisfactorily answered all my questions. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that all my questions regarding the treatment with Reaction have been answered satisfactorily. By signing below, I acknowledge that I have read the foregoing informed consent and give consent to this and all subsequent treatments with its associated risks. I hereby release LaViva M.D. Medical Corporation (DBA: vivaMD), Medical doctor, Nurses, all other medical providers and employees of this corporation (Regular/ on training) from any liability associated with the treatment.

Patient Name: _____ Date: _____

Patient Signature: _____

REACTION SKIN TIGHTENING/CELLULITE REDUCTION/BODY CONTOURING PRE & POST CARE INSTRUCTIONS

Before Treatments:

- Do not use alcohol-based cleaning solutions.
- Ensure that there is at least an hour between your last meal and your abdomen treatment. - Drink about 1.5 liters of water before each treatment session. - Stay hydrated (drinking at least 1 liter of water daily) during your entire course of treatment. - If you exercise regularly, Reaction™ treatments should be performed before the physical activity.

After Treatments:

- Redness and swelling in the treated area may occur and is a normal reaction. Use cold compresses only in the presence of adverse effects, to help alleviate the symptoms.
- Following treatment, avoid the use of hot water and discontinue use of abrasive or harsh products for two days. - In cases where superficial crusting or scabbing occurs, do not rub, scratch or remove the scab. Cleanse the area gently and pat dry.
- Apply a high factor sunscreen (at least 30 SPF) and protect the treated area from sunlight for two weeks following treatment.
- Make-up may be applied immediately after the treatment. - If you have excessive heat sensation that causes a lot of - If you have excessive heat sensation that causes a lot of discomfort, you can cool the area with chilled Aloe Vera gel.

Setting Expectations:

- Adherence to a healthy lifestyle (diet and exercise) is strongly recommended and may help to obtain better results.
- Maintenance sessions may be required (one maintenance session every 3-6 months).
- Response to the Reaction™ treatment, and the number of treatment sessions required will vary among patients and will depend on the clinical and physiological condition at the start of the treatment regimen.
- Weight gain or dramatic weight loss may have a negative effect on the results. - If you have excessive heat sensation that causes a lot of discomfort, you can cool the area with chilled Aloe Vera gel.

Patient Name: _____ Date: _____

Patient Signature: _____