



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: _____

LASER TATTOO/SCAR REMOVAL INFORMED CONSENT

The purpose of this Informed Consent is to help you decide whether laser tattoo removal (LTR) cosmetic procedure is right for you and to help you make an informed decision to undergo this procedure. This Informed Consent give you general information about this cosmetic procedures, explains other treatment options, and identifies the benefits, risks, side effects and possible complications associated with LTR procedures.

The laser that will be used has been cleared for distribution by the FDA for this use, and lasers like this one have been in clinical practice for years. The overall goal is to attempt removal of the tattoo, ink, mark, and lesions or to make the colors or decorative pattern as unrecognizable as possible by lightening the pigment pattern. The number of treatments varies between 6-12 and depends on skin color, ink color (green and yellow are least responsive), ink depth, size, and age of tattoo. **Please inform us if your tattoo is older than 20 years old.** While we strive for this outcome, and use the most advanced laser technology available to achieve an optimal result, this may not occur.

Alternative Procedures: Camouflaging with make-up, tattooing over with a second tattoo, abrasive treatments, CO2 laser removal, cutting out/excising the tattoo (with tissue expansion or skin grafting if needed), or no treatment at all.

Not good candidates: Generally you are not a good candidate for LTR procedures if: **1.** Pregnant or are trying to become pregnant **2.** Ink allergy **3.** Immune compromised condition **4.** Permanent Cosmetic Ink/Permanent Make-Up.

Risks and Complications: **1.** There is a risk of eye damage from lasers, which will be minimized by the wearing of protective goggles during laser use. **2.** Clinical end points will change throughout course of treatment. **3.** Frosting (a white film) will appear on the skin only after the first treatment. **4.** Risk of patchy residual pigment, persistence of tattoo pattern, change or permanent lightening of skin color, change in skin texture or hair loss/thinning. **5.** Blistering and pinpoint bleeding may occur and is normal. You should elevate the treated area above the heart and minimize activity while the area is healing. **6.** Pain, discomfort, stinging, discoloration, redness, bruising, swelling, blistering, and crusting are common, but infection is rare. **7.** Previous treatment by any other method may increase any or all of these risks. **8.** Scarring is a rare possibility. **9.** Irregular pigmentation and mild texture changes can occur as a result of laser treatment, but these changes usually return back to “normal” over a period of 6 months to 1 year after final treatment. **10.** After each treatment different amounts of fading will occur ranging from very little to significant amounts during the course of treatment. **11.** Despite our best efforts there remains the possibility that not all of the ink will be removed. Certain colors and certain types of ink may be more difficult to remove and many may appear darker before getting lighter.

Anesthetic Requirement: A topical numbing cream will be used. This should be applied approximately 10-15minutes before your scheduled sessions. If you prefer to have a numbing cream prior to treatment, the cost is \$150 and will be used only for your treatment/s. Should you opt to have local anesthesia injected by our physician, this can be arranged but additional costs will apply to all injections.

Post Procedures Instructions: It is important that you comply with all post procedure instructions. Please call your doctor promptly if complications develop after the procedure. Laser-treated areas should not be exposed to sun or tanning beds. Not adhering to the post treatment skin care instructions may increase the risk of complications.

LASER TATTOO REMOVAL INFORMED CONSENT CONT.

I acknowledge that: The information contained in this Informed Consent was explained to me using terms I could understand, and all my questions and concerns have been answered. After reviewing all the information provided to me about cosmetic procedures and reviewing my health status, I believe I am a good candidate for LTR procedure.

- **I confirm my tattoo is no older than 20 years old.** I understand that LTR is an elective procedure and hereby freely accept all possible risks, complications, side effects that may result from this procedure.

- I understand that I am responsible for the cost of numbing cream and will inform vivaMD Medical staff of need during my initial consultation.

- If there is a history of Lupus, Herpes simplex or light sensitivity, I will let my provider know and to take the necessary means to protect myself by taking medication or avoiding therapy as directed.

- It is my responsibility to follow the appropriate aftercare instructions as explained and written in the post-care instruction that are given after treatment.

- No absolute guarantee of any kind has been made to me, by either the doctor or staff regarding the procedure, the number of procedures or its final outcome.

- I have discussed the Procedure, Alternative treatments, Risks for Laser Tattoo Removal and had the opportunity to ask questions with my doctor and/or staff members.

- The treatment will be performed by a Medical professional. I agree to the photographing of my tattoo and procedure. We may use these photographs only for illustrative purposes.

- This consent form is valid for all future laser tattoo removal treatments performed, and I will alert the staff if there are any future changes or my medical history, or if I become pregnant.

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 procedure have been answered satisfactorily. By signing below, I acknowledge that I have read the foregoing informed consent and agree to this treatment with its associated risks and I will alert the staff if there are any future changes or my medical history, or if I become pregnant.. I hereby give consent to perform this and all subsequent treatments with the above understood. I hereby release LaViva M.D. Medical corporation, Medical doctor, and all other medical providers and employees of this corporation (Regular/ on training) from liability associated with this procedure.

I have received and understand the pre /post care instructions and will follow them.

Patient Name: _____

Date: _____

Patient Signature: _____

Laser Tattoo Removal Aftercare Instructions

Day of Treatment (Day 1):

1) Ice: It is vital to apply an ice compress to site on and off for the first hour. Alternate the compress on and off every 1-3 minutes as needed. DO NOT leave ice on the treated area for more than 5 minutes. Natural Aloe Vera gel may also be applied. **2) Rest:** Limit physical activity on this day. Avoid exercising and any activity that results in perspiring. Avoid hot steamy showers and harsh soaps/cleansers. **3) Elevate** the treated area above the heart when possible. This is especially important for tattoos on the lower leg, ankle and feet. **4) Skin Reactions:** Please note your treatment site may exhibit different tissue reactions after each treatment. The following signs and symptoms that are normal after laser treatment: **1.** The treatment site appears unchanged or appears brighter. **2.** The area will appear white, pink, or red. **3.** The treatment site has pinpoint bleeding, blistering or red, yellow, or clear discharge and swelling.

Day after Treatment (Day 2) 1) Ice:

Continue to apply ice compress as noted above only as needed for burning. **2) Moisturize:** Apply Vaseline or Aquafor 3-4 times a day for the first 3 days after treatment to promote healing and reduce itching and irritation. **3) Rest and Elevation:** Continue to rest and elevate (especially important for tattoos on the ankle or foot). Limit physical activities such as working out, sports, etc.

Day 3 Until and Healed:

1) Moisturize: Keep treatment site well moisturized with Vaseline or Aquafor.
2) Avoid: Any over the counter anti-bacterial ointments or creams as they may cause allergy!
3) Activities: You may resume activities unless a blister is present. Avoid swimming pools, ocean, and hot tub and tub soaking pedicures for 5-7 days until healed
4) Blistering: Blistering is normal. Do not pop or pick blisters. Blisters may take 1-2 weeks to resolve. You may use a nonstick bandage to protect the blister. If blister breaks apply Aquafor and a non-stick bandage.
5) Healing: Do not pick or remove scabs or crusts that develop during the healing process. *This is a leading cause of infection and can lead to scarring.* Healing can take anywhere from 5 to 25 days (or more). Infections are rare, however if aftercare is not followed they can occur. The signs to look for are foul odor, fever, red streaks from area, yellow-green drainage, and pain. Call the office if you suspect an infection.
6) Before your next appointment: Apply SPF 50 or higher to tattoo when in direct sun light, avoid spray tanning for 2 weeks before/after, and shave area day before next treatment.
7) NEXT APPOINTMENT: Should be booked in 6-12 weeks. It takes the body up to four weeks to break down the ink so results will not be immediate and every treatment will react differently. I acknowledge that I received written and verbal post instructions.

Patient Name: _____

Date: _____

Patient Signature: _____