OPTIMAL
WELLNESS & AESTHETICS

# NOTICE OF NON-COVERED SERVICES AND/OR PRODUCTS

# AND PATIENT ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Based upon your clinical symptoms and/or diagnosis, and after a consultation with our physician, you have requested the services or products related to your condition. This Notice of Non-Covered Services and Acknowledgement of Financial Responsibility will assist you in understanding your financial responsibility for the products.

Our office does not expect the services or products to be covered by your Insurance plan for the treatment of your sexual or erectile dysfunction. Therefore, by signing below, you acknowledge that you are financially responsible for the products and you agree to pay for them in full at the time of your visit.

**OUR OFFICE WILL NOT SUBMIT A CLAIM FOR PRODUCTS TO ANY INSURANCE COMPANY ON YOUR BEHALF.**

Print Patient Name: _____

Patient Signature: _____

Date: _____

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## GOOD FAITH EXAM

**PATIENT NAME:** _____ **DOB:** _____

**DO YOU HAVE?**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| | | Hypersensitivity to botulinum a toxin product | | | Infection at the proposed injection site(s) |
| | | Active skin disease | | | Amyotrophic lateral sclerosis |
| | | Motor neuropathy | | | Myasthenia gravis |
| | | Lambert-Eaton syndrome | | | Facial nerve palsy |

**DO YOU TAKE OR HAVE RECENTLY BEEN ON ANY OF THE FOLLOWING MEDICATIONS?**

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| | | Warfarin or anti-platelet agents (aspirin, Plavix) | | | Quinidine (treats malaria and irregular heartbeats) |
| | | Aminoglycosides (antibacterial med) | | | Magnesium sulfate (used for short term relief) |
| | | Curare-like nondepolarizing blockers(steroidal) | | | Anticholinesterases (Alzheimer's medications) |
| | | Lacosamide's (antibiotics) | | | Succinylcholine chloride (neuromuscular blocker) |
| | | Polymyxins (antibiotic) | | | |

## **STOP HERE AND SIGN BELOW**

**** TO BE COMPLETED BY MD, NP, OR PA ****

- ☐ Medical history and current medications have been reviewed.

Relative medical history:

_____

- ☐ Intake Form reviewed.
- ☐ Patient is not taking Contraindicated medications.
- ☐ Client is not Pregnant or Breastfeeding.

LMP: _____ LAST PAP: _____

- ☐ Patient is determined to be healthy enough to be considered low risk for complications.

Limited Physical Examination: _____

- ☐ No known hypersensitivity or reactions to medications.

Allergies and Reactions if so:

_____

- ☐ Patient has no bleeding or clotting disorders. Patient has been advised to avoid alcohol, aspirin, and non-steroidal anti-inflammatories prior to the procedure.

Patient has bleeding and bruising risk: _____

- ☐ Patient has no Cardiac risk factors such as arrhythmia or severe coronary artery disease that could be worsened by medical procedures.

Patient has Cardiac Risk Factors: _____

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| | | Glabellar lines smoothed out by spreading apart | | | Skin infection at site of injection |
| | | Evidence of muscular atrophy | | | Evidence of petechia or bruising |
| | | Facial asymmetry | | | Ptosis |
| | | Deep dermal scarring | | | Thick sebaceous skin |
| | | Dermatochalasis | | | |

**Comments:**

_____

_____

Upon Review of the available information regarding patient's current and past medical history, medications, and overall physical health profile our Medical Professionals have reasonable medical certainty to proceed with the treatment plan offered at Optimal Wellness & Aesthetics. Understanding that a patient's medical history and medications may change over time requires updates and evaluation by our clinicians for any current and future treatments. It is a duty and obligation for patients to inform and the treating clinicians to update any recent changes in their medical history to ensure the safety of on-going medical aesthetic treatment plans. Authorization will be obtained prior to treatment. If there are changes in medical conditions, new medications, or concerns about any increased complication risk based on the information listed above.

The signature of this document represents that a medical review and evaluation has been performed. It has been determined that there is reasonable and medical certainty insuring a low acceptable risk profile related to any procedures provided by Optimal Wellness and Aesthetics.

Patients Name: _____ Signature: _____ Date: _____

Physician signature: _____ Date: _____

Do you use tanning booths? YES / NO

Do you form thick or raised scars? YES / NO

Do you have any thick or raised scars? YES / NO

Do you have Hyper Pigmentation (darkening of the skin) or Hypo Pigmentation (lightening of the skin) or marks after physical trauma?

YES / NO If yes, please describe: _____

Do you have Melasma (patchy brown discoloration of skin when heat is present)? YES / NO

If yes, what area or areas? _____

Have you ever taken Accutane? YES / NO

Do you use any Acne Medication? YES / NO

If yes, Pleas list: _____

**Skin Type**

| | | | |
|---|---|---|---|
| | Sunburn Easily | | Sun burn, then Tan |
| | Usually, Tan | | Always Tan |
| | Sensitive | | Oily |
| | Dry | | Normal |

**Pregnancy**

Are you currently pregnant? YES / NO

Have you been pregnant? YES / NO

Pregnancies? _____ Births? _____

Are you currently Breast feeding? YES / NO

Are you planning on getting pregnant soon? YES / NO

Are you currently taking birth Control? YES / NO

If yes, What kind of Birth Control (pills, IUD, condoms)? _____

**SURGERIES**

Do you have any scheduled surgeries? YES / NO

If yes, for what? _____

Have you received any surgeries? YES / NO

If yes, What Procedures and Dates? _____

_____

_____

## All Patients:

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor, or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Print name: _____ Signature: _____ Date: _____

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## GENERAL HEALTH HISTORY

Are you currently under the care of a physician? YES / NO

If yes, for what reason? _____

_____

Any Medications? Vitamins, Herbs, or Ointments? YES / NO

If yes, name of Medications? _____

_____

_____

**USES**

Tabacco: YES / NO Amount: _____ Coffee/ Tea/ Soda: YES / NO Amount: _____

Alcohol: YES / NO Amount: _____ Daily Exercise: YES / NO Amount: _____

Ibuprofen: YES / NO Amount _____ Daily Aspirin: YES / NO Amount: _____

**ALLERGIES**

Seasonal allergy: YES / NO

Medication Allergy: YES / NO Name & Reaction-_____

Latex Allergy: YES / NO Source & Reaction-_____

Tape Allergy: YES / NO Type & Reaction-_____

**MEDICAL HISTORY**

### DO YOU HAVE OR HAD ANY OF THE FOLLOWING?

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| | | High Blood Pressure | | | History of Kidney Stones |
| | | Heart Attack | | | Ulcers |
| | | Irregular Heartbeat | | | Reflux/ Heartburn |
| | | Cardiac/ Disease | | | Pancreatitis |
| | | High Cholesterol | | | Arthritis |
| | | Heart Disease | | | Muscle Weakness |
| | | Respiratory Illness | | | Hepatitis |
| | | Sleep Apnea | | | HIV/ Aids |
| | | Asthma | | | Head Injury/ Stroke |
| | | History of Lung Problems | | | Seizures |
| | | UTI | | | Depression |
| | | Bleeding/ Blood Clotting Problems | | | Headaches |
| | | Diabetes | | | Breast Masses |
| | | Thyroid | | | Other: |
| | | Cancer | | | |

**If yes to Any Responses Please Describe:** _____

_____

**SKIN**

Are you currently under the care of a dermatologist? YES / NO

If yes, for what? _____

Have you had any recent tanning, use of self-tanning lotions, or sun exposure that changed the color of your skin? YES / NO

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# PATIENT INFORMATION

## BASIC PERSONAL INFORMATION

| | | | |
|---|---|---|---|
| FIRST NAME: | | MIDDLE NAME: | |
| LAST NAME: | | SEX | |
| DATE OF BIRTH: | | _____ MALE | _____ FEMALE |
| HOME PHONE: | | CELL PHONE: | |
| EMAIL: | | | |
| HOME ADDRESS: | | | |
| CITY: | STATE: | | ZIP CODE: |
| MAILING ADDRESS: **(If different than Home)** | | | |
| CITY: | STATE: | | ZIP CODE: |
| | | | |

## CONTACT INFORMATION

| | | |
|---|---|---|
| FIRST NAME: | | |
| LAST NAME: | | |
| RELATIONSHIP TO YOU: | | |
| PHONE: | EMAIL: | |
| ADDRESS: | | |
| CITY: | STATE: | ZIP CODE: |

## HOW WAS YOU REFERRED TO US?

- ❑ FRIEND: NAME: _____
- ❑ INTERNET WEBSITE: _____ GOOGLE SEARCH _____ FACEBOOK _____ TIKTOK _____ INSTAGRAM
- ❑ WALKING BY
- ❑ OTHER (PLEASE SPECIFY): _____

## TREATMENT REQUESTED

| | | | |
|---|---|---|---|
| | BOTOX | | LASER SKIN REJUVENATION |
| | FILLER (VOLUMA, JUVEDERM) | | ACNE |
| | MICRO NEEDLING | | HORMONES |
| | ACNE SCARS | | INJECTIONS |
| | PIGMENTATION/ BROWN SPOTS/ SUN DAMAGE | | IV THERAPY |
| | WRINKLE REDUCTION | | WEIGHT MANAGEMENT |
| | PRP | | SEXUAL WELLNESS |
| | LASER HAIR REMOVAL | | HAIR RESTORATION |
| | HYDRA FACIAL | | OTHER: |

**MAY WE CONTACT YOU FOR PROMOTIONS VIA EMAIL AND OR TEXT? YES / NO**