The Youth Fountain, LLC

501 Iron Bridge Road, Suite 9
Freehold, NJ 07728
(866) 514-0025

Aesthetics Form

Name: ____________________________________ Date: __________________ Email: ______________________________

Birthdate: ____________________ Female: ________ Male: __________

Primary Care Physician Name: ___________________________ How did you hear about us? ___________________________

What are you here for today? ____

Current Medications/Supplements and Doses: ____

____

Current Skin Care Products: ____

Allergies/Reaction: ____

What feature are you most unhappy with? ____

Have you heard of:	Yes	No	Do you have:	Yes	No
CoolSculpting			Muffin-Top		
Plasma Facelift			Love Handles		
TruSculpt			Extra arm fat		
IV Therapy			Sagging Skin / Lumpy Knees		
Microneedling			Cellulite		
Pico Genesis			Saddlebags		
VI Peel			Acne Scars		
EmSculpt			Double Chin		

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Have you undergone any cosmetic procedures? ____

____

____

Past Medical History: ____

____

Past Surgical History: ____

____

Smoke, if yes how much? __________________________

Drink alcohol, if yes how much? __________________________

Recreational drugs, If yes which and how much? ____

Plan on becoming pregnant soon? Yes / No

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal health care information. Please read it carefully before signing.

The Youth Fountain, LLC will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use or disclosure. YOU MAY REFUSE TO SIGN THE AFOREMENTIONED AUTHORIZATION.

By signing this authorization, you acknowledge and agree that The Youth Fountain, LLC may not use or disclose any health care related documentation for the purpose(s) of treatment or management of the patient's health without patient permission.

By signing this authorization, you agree that The Youth Fountain, LLC or its Business Associates may not disclose your personal health care information to a requesting entity or health care provider without your express permission.

Further, by signing this authorization, you acknowledge that you have been provided a copy of and have read and understand The Youth Fountain, LLC Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While The Youth Fountain, LLC has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from The Youth Fountain, LLC at any of its offices.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by The Youth Fountain, LLC for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that The Youth Fountain, LLC has taken action in reliance on it. A revocation is effective upon receipt by The Youth Fountain, LLC of a written request to revoke and a copy of the executed authorization form be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of The Youth Fountain, LLC or (d) six years from the date this authorization was executed.

By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

The Youth Fountain, LLC will provide the undersigned with a copy of this signed authorization at his or her request.

Acknowledge and agreed to by:

Patient Name: ____ Date: _____________________

Patient Signature: ____

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Patient Registration Form

Patient Information

Name: ____ Date: ____________________

Address: ___________________________________ City: ________________ State: _________ Zip: _____________

Age: _______________ Birthdate: ______________________ Female / Male

SSN (Last 4 Digits): _____________________ Email Address: ____

Home Phone: _____________________________ Work Phone: _____________________________

Cell Phone: ______________________________

How would you prefer to receive automatic appointment reminders? ☐ Text ☐ Call ☐ E-Mail

Employer: ____ Occupation: _____________________________

Address: _____________________________ City: ______________________ State: _________ Zip: _____________

Emergency Contact: _________________________________ Phone Number: _________________________