Avante
Laser & MediSpa

Client Information (please print)

Date_____

First Name _____ Last Name _____ M.I. ____

Address_____

City _____ State _____ Zip Code _____

HomePhone_____Mobile_____ Work_____

Our main way of telling you of our specials is through email. ***Please give us your email if you would like to receive specials.***

E-MAIL ADDRESS:_____

We provide courtesy appointment reminder calls the day prior to your appointment. ***Would you like to receive a confirmation call?*** **Yes ◯ No ◯**
If yes, please tell us the TWO methods (in order of preference) you would like to be contacted. Please make sure it is a number and/or email address where we can leave a message and you will check daily.

First choice of contact: cell ◯ home ◯ email ◯ text message ◯

Second choice of contact: cell ◯ home ◯ email ◯ text message ◯

Date of birth _____ Sex: M ◯ F ◯

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed

Profession _____

How did you hear about us?

Friend _____ (If it is a client of ours, please share their name so we can send them a thank-you gift.)

Internet ◯ Magazine ◯ Newspaper ◯ Other ◯_____

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Client Medical History

Name:_____ Birthdate_____ Date:_____

Medical (Please Circle N for No and Y for Yes)

Acne	N O Y O	Fainting	N O Y O	Keloid Scars	N O Y O	Pacemaker	N O Y O
Anaphylaxis	N O Y O	Genital Herpes	N O Y O	Metal Pins	N O Y O	Pigmentation	N O Y O
Bruises Easily	N O Y O	Hearing Aid	N O Y O	Migraines	N O Y O	Seizures	N O Y O
Canker Sores	N O Y O	Heart Condition	N O Y O	Mitral Valve Prolapse	N O Y O	Telangiectasia	N O Y O
Carcinoma	N O Y O	Hemophilia	N O Y O	Moles	N O Y O	Thyroid Disorder	N O Y O
Cold Sores	N O Y O	Hepatitis	N O Y O	MSRA	N O Y O	Tuberculosis	N O Y O
Contact Lenses	N O Y O	High Blood Pressure	N O Y O	Obesity	N O Y O	Vitiligo	N O Y O
Dermatitis/Eczema	N O Y O	Histamine Reactions	N O Y O	Ovarian Disorder	N O Y O		
Diabetes	N O Y O	HIV	N O Y O	Previous Surgeries List:	N O Y O	Implants Type:	N O Y O

Are you allergic to any of the following? (Please Select)

Rubbing Alcohol ☐ Witch Hazel ☐ Latex Gloves ☐ Aloe Vera ☐ Metals ☐ Essential Oils ☐ Lidocaine ☐
- No Known Allergy ☐ Other ☐

Please explain any above Medical Issues In detail:_____

Please list any medications/supplements you are currently taking: _____

I will notify Avante of any changes in medication or of any new medications that I am taking.
*(Sign)*_____ *Date:*

For Females Only

In Menopause	N O Y O	Hormonal Imbalance	N O Y O	Endocrine Problem	N O Y O
Post Menopause	N O Y O	Pregnant	N O Y O	Hysterectomy	N O Y O
Regular Periods	N O Y O	Birth Control Pills	N O Y O	Other	

Laser Clients (ONLY) Treatment Areas (Please Select)

Abdomen	☐	Chest	☐	Feet/Toes	☐	Neck: Front/Back	☐
Arms: Fore/Under	☐	Chin	☐	Hairline	☐	Nose	☐
Back	☐	Ears	☐	Hands/Fingers	☐	Private Areas	☐
Bikini: Line/Full	☐	Eyebrows	☐	Lip: Upper/Lower	☐	Thighs	☐
Breast	☐	Face: Sides/Full	☐	Legs	☐	Other	☐

At what age was onset of hair growth? _____ Was onset sudden or gradual? _____
Family members with similar growth patterns_____
Do you have a dark centerline of heavy hair growth on the abdomen or between the breasts? **No** ○ **Yes** ○
What temporary procedures have you been using to rid the hair? (Please circle) Tweezing ☐ Shaving ☐ Waxing ☐
How often do you have to perform this procedure? (daily, weekly, etc…) _____
Have you had previous electrolysis or laser treatments? **No** ○ **Yes** ○ When? _____ Area?

Did you experience any adverse skin reactions to your treatment? **No** ○ **Yes** ○ Explain
Provider's Signature:_____ Date:_____

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Microblading - Client Medical History

First Name:_____ **Last Name:**_____
Birth date:_____ **Address:**_____
Phone No.:_____ **Email:**_____
Emergency Contact:_____ **Phone No.:**_____

Do you have or have you had any of the following: (Circle Yes or No)

Yes ○ No ○ History of MRSA
Yes ○ No ○ Botox (last treatment_____)
Yes ○ No ○ Diabetes
Yes ○ No ○ Hepatitis A B C D
Yes ○ No ○ Forehead/Brow Lift
Yes ○ No ○ Easy Bleeding
Yes ○ No ○ Facelift
Yes ○ No ○ Abnormal heart condition
Yes ○ No ○ Take medication before dental work
Yes ○ No ○ Chemical Peel (last treatment_____)
Yes ○ No ○ Pregnant now or Breastfeeding now
Yes ○ No ○ Brow or Lash Tenting (last treatment_____)
Yes ○ No ○ Autoimmune Disorder
Yes ○ No ○ Oily Skin
Yes ○ No ○ Cancer (Year?_____)
Yes ○ No ○ Accutane or Acne Treatment
Yes ○ No ○ Chemotherapy/Radiation
Yes ○ No ○ Tan from tanning bed or spray tan
Yes ○ No ○ Tumors/Growth/Cysts
Yes ○ No ○ Difficulty numbing with dental work
Yes ○ No ○ Taking blood thinners such as: Aspirin, Ibuprofen, Alcohol, Coumadin, etc…
Yes ○ No ○ Allergic reaction to any medications such as: Lidocaine, Tetracaine, Epiephrine, Dermacaine, Benzyl Alcohol, Carbopol, Lecithin, Propylene Glycol, Vitamin E Acetate, etc…
Yes ○ No ○ Allergies to metals, foods, etc…_____
Yes ○ No ○ Any diseases or disorders not listed:_____
Yes ○ No ○ Do you use skin care products containing Retin-A, Glycolic Acid, or Alpha Hydroxyl?

Please list any medications you are currently taking:_____

I agree all of the above information is true and accurate to the best of my knowledge.

Signature:_____ Date:_____

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Microblading Consent

Name:_____ Date:_____

☐ Aftercare instructions have been explained to me and a written copy has been given to me to retain in possession, which I will follow to the best of my ability. If I have questions, I will call or email you.

☐ I understand that a certain amount of discomfort is associated with this procedure, and that swelling, redness and bruising may occur.

☐ I understand that Retin A, Renova, Alpha Hydroxy and Glycolic Acids must not be used on the treated areas. They will alter the color and cause premature exfoliation.

☐ I understand that tanning beds, pools, some skin care products and medications can affect my permanent makeup.

☐ I understand that successful color saturation can NOT be guaranteed due to hidden scar tissue.

☐ I will tell all skin care professionals or medical personnel about my permanent makeup procedures, especially if I am scheduled for an MRI.

☐ I accept the responsibility to explain to you by desire for specific colors, shape, and position for any procedure done today and in the future.

☐ I understand that implanted pigment color can slightly change or fade over time due to circumstances beyond your control, and I will need to maintain the color with future application and touch-up session within 60 days.

☐ I acknowledge that the proposed procedure[s] involve risks inherent in the procedure, and have possibilities of complications during and/or following the procedures such as: infection, misplaces pigment, poor color retention and hyper-pigmentation.

☐ I have been advised that a touch-up session is highly recommended to make any adjustments to shape, color, and to fill any pigment that may have had poor retention. **Touch-ups must be completed within 4-6 weeks of initial treatment.**

☐ I have been quoted the cost of today's appointment, and the cost of touch-up. Touch-ups must be completed within 60 days of initial procedure to be considered a touch-up price.

I certify I have read or have had read to me the contents of this form. I understand the risks and alternatives involved in this procedure. I have had the opportunity to ask questions, and all of my questions have been answered. I acknowledge I have reviewed and approved the material given to me, and I authorize Megann Chesshir, as my Eyebrow Microstroking technician to perform this procedure today.

Signature: _____

Provider's Signature:_____ Date:_____

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Microblading – After-care Instructions

It is essential that you follow these instructions after your Microblading session:

Day One (Day of Treatment): Aquaphor is recommended, and is available in the skincare section of any drug store. Apply the post-care cream with a cotton swab for 9 days after the treatment. Do not use any aggressive movement and/or manipulation of the skin. Wash your hands with a disinfectant soap before washing your eyebrows and/or applying the post-care cream.

Day Two to Day Nine: Apply the post-care cream (Aquaphor, Grapeseed Oil) with a cotton swab. Again, do not use any aggressive movement while applying. Wash your hands with a disinfectant soap before washing your eyebrows and/or applying the post-care cream.

The following **must be avoided** during all nine days post-microblading procedure:

- Increased sweating. It is recommended not to sweat (heavily) for the first 10 days after the procedure. Sweat is salt and can prematurely fade the treated area.
- Practicing sports
- Swimming
- Hot sauna, hot bath, or Jacuzzi
- Sun tanning or salon tanning. Absolutely NO sun, sweating, or tanning prior to the procedure for 10 days. Do not have a tan/sunburn on your face prior to procedure. The tan will exfoliate taking color with it as it fades.
- Any laser or chemical treatments or peelings, and/or any creams containing Retin-A or Glycolic Acid on face or neck.
- Picking, peeling, or scratching of the micro pigmented area in order to avoid scarring of the area or removal of the pigment.
- Performing tasks related to heavy household cleaning such as garage or basement cleaning where there is a lot of airborne debris.
- Spicy foods
- Smoking
- Drinking alcohol in excess, as it may lead to slow healing of wounds
- Driving in open-air vehicles such as convertibles, boats, bicycles, or motorcycles
- Touching the eyebrow area except for when rinsing and applying with the cotton swab post-care cream

Before showering, apply a layer of post-care cream to protect your eyebrows from moisture. During the shower, keep your face away from the showerhead.

Itching and flaking may appear during the first seven days post-microblading procedure. However, experience has shown that by following these after-care instructions, these symptoms usually quickly disappear.

The healing of deeper wounds might last between 14-21 days. Touch-up and/or correction of the shape-design are recommended only after this period.

Client Treatment Consent and Release

I acknowledge that beauty treatments, the practice of skin care, and the practice of massage, including, but not limited to micro ablation, microdermabrasion, electrolysis, facial toning, permanent cosmetics, body treatments, ionization, laser treatments, tattoo removal, vein treatments, brown spot removal, BOTOX, Collagen, Dermal Fillers, Sclerotherapy, Mesotherapy, Dermaplaning, and various other beauty procedures is not an exact science, ***therefore, we do not offer refunds on services rendered. Aesthetic results are quite variable from person to person and while we do our best to achieve the desired outcome it cannot always be guaranteed. Clients are responsible for further treatments needed to achieve further results,*** *and no specific guaranties can or have been made concerning the outcome. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference.*

I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, and change in skin pigmentation, allergic reaction, muscle damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insureds, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive.

I have fully disclosed on my client intake form any medications, previous complications, or current conditions that may affect my treatment. I understand and agree that any legal action of any kind related to any treatment I receive will be limited to binding arbitration using a single arbitrator agreed to by both parties.

X _____ *Date:*_____
Client Signature

*Printed Name*_____

Model Release

In consideration for treatment received, I hereby grant permission to the individual or company that provided my treatment to use any photographic treatment records for the purposes of clinical and statistical studies, advertising, or promotion without any additional compensation to me.

X_____ *Date:*_____
Client Signature

*Printed Name*_____

Rev. 05/29/20

Avante
Laser & MediSpa

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY OUR PRACTICE AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE BECAME EFFECTIVE 12/16/2013

If you have any questions about this notice, please contact Carrie Boswell at 281-419-0080.

PROVIDER/CLINIC OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect
- In Texas, inform you that we disclose your Protected Health Information (PHI) electronically
- In Texas [Describe how the practice uses electronic media to communicate with patients if applicable]
- In Texas we will not email patients without written consent
- Notify you of a breach of protected information as required by federal and state law

PROTECTED HEALTH INFORMATION:
Protected health information is defined by HIPAA as individually identifiable health information; it can be verbal, written or electronic.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:
The following describes the ways we may use and disclose Health Information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
For Payment: We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

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For Health Care Operations: We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research: Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation: If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation: We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your Health Information.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities: We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. The release, if necessary, would be for the institution: (1) to provide you with health care; (2) to protect

your health and safety or the health and safety of others; or (3) to provide the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person your identity and your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief: We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy: You have a right to inspect and obtain a copy of Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Carrie Boswell. In Texas, we have up to 15 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

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Right to an Electronic Copy of Electronic Medical Records: If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach: You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend: If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Carrie Boswell.

Right to an Accounting of Disclosures: You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Carrie Boswell.

Right to Request Restrictions: You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Carrie Boswell. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments: If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Carrie Boswell. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still

entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.avantemedispa.com. To obtain a paper copy of this notice you must make your request in writing to, Carrie Boswell.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page of the notice.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Carrie Boswell. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

All articles and any forms, checklists, guidelines and materials are for generalized information only, and should not be reviewed or referred to as primary legal sources nor construed as establishing medical standards of care for the purposes of litigation, including expert testimony. They are intended as resources to be selectively used and always adapted – with the advice of the organization's attorney – to meet state, local, individual organizations and department needs or requirements. They are distributed with the understanding that neither Texas Medical Liability Trust nor Texas Medical Insurance Company is engaged in rendering legal services.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FOR AVANTE LASER & MEDISPA

Patient Name: _____

Date of Birth: _____

I acknowledge that Avante Laser & MediSpa has provided me with a written copy of their Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature _____

Printed Name _____

Date _____

Personal Representative Signature (if applicable):_____
Printed Name_____
Relationship to Patient: _____

I ALSO GIVE MY CONSENT TO RECEIVE HEALTH INFORMATION BY EMAIL FROM AVANTE LASER & MEDISPA **(IF YOU DO NOT SIGN THIS PORTION AND YOU ARE ALREADY RECEIVEING E-MAILS, YOU WILL NO LONGER RECEIVE E-MAILS FROM AVANTE. YOU MUST SIGN TO RECEIVE E-MAIL!)**

SIGNATURE_____

E-MAIL ADDRESS_____

OFFICE NO-SHOW POLICY AGREEMENT

Printed Name: Date:

As a patient of Avante Laser & MediSpa and recipient of services and/or products provided by Avante Laser & MediSpa, I do acknowledge, understand, and consent to adhere to the office policies outlined below:

- If should arrive at least 15-20 minutes (or at least 30 minutes if I am new patient) before my scheduled appointment time to check-in and complete or update any patient information forms (most are required annually). It is my responsibility to provide current and complete requested personal and medical information and current insurance information to Avante Laser & MediSpa at the time of appointment scheduling. I may not see the provider until my paperwork is completed. Providing incomplete, out-of-date, inaccurate, or unverified patient information may result in delay of my scheduled appointment time or rescheduling of my appointment.

- All past balances are due at time of check-in for my appointment. I may not see an Avante Laser & MediSpa provider until all outstanding balances have been reconciled; otherwise, **my appointment will be rescheduled**.

- If I cannot keep my appointment time and must cancel, I must notify the Avante Laser & MediSpa office staff at least 24 hours before my appointment time.

After ONE no-show without advanced 24-hour notification, my account will be charged a no-show fee per incident as follows:

- $50 per no-show for an office visit

No-show fees are part of the balance due and must be paid BEFORE my next appointment may be scheduled.

Patient Signature: