NOOR
LASER MEDSPA

MEDICAL INFORMATION FORM

Name: _____ Date: _____

DOB: _____ Age: _____ ☐ Male ☐ Female

Address: _____ City / State / Zip _____

Cell Phone: _____ Email: _____

How did you hear about us? _____

Have you ever had any of the following injections? (Check all that apply)

☐ Botox ☐ Dysport ☐ Perlane ☐ Collagen ☐ Radiasse ☐ Juvederm

When and what area? _____

Have you ever had and of the following treatments? (Check all that apply)

☐ Laser Resurfacing (Fractional or ablative) ☐ Laser Hair Reduction ☐ Permanent Makeup

☐ Laser Vein Reduction ☐ Microdermabrasion ☐ Facelift ☐ Liposuction ☐ B-12

☐ Photo Facial ☐ Tattoo Removal ☐ 1064 Laser Facial – ALMA Clear Lift ☐ Toenail Fungus

☐ Cellulite Therapy ☐ Skin Tightening ☐ Lamprobe – skin tag removal ☐ Micro Needling

☐ Chemical Peels, what kind _____

☐ Other Cosmetic Surgery _____

Do you regularly use tanning salons, Bronzers or sunbathe? _____ How often? _____

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Medical History

Are you currently under the care of a physician Dermatologist? ☐Yes ☐No

List all medications / herbal remedies you are currently taking _____

_____

List all known food / medication allergies _____

List and date all surgeries _____

Are there any other medical conditions you have been diagnosed with or treated for ☐Yes ☐No

If yes explain _____

Do you wear contact lenses? ☐Yes ☐No

Are you sensitive to cold? ☐Yes ☐No

Do you bruise easily? ☐Yes ☐No

Do you hive easily? ☐Yes ☐No

Have you had a loss or increase of pigmentation upon injury to the skin? ☐Yes ☐No

Have you ever used Renova, Differin, Tazorac, or Retin-A? ☐Yes ☐No Last dose? _____

Are you taking antidepressants? ☐Yes ☐No Type? _____

Are you taking hormones? ☐Yes ☐No Type? _____

Are you taking blood thinner? ☐Yes ☐No Type? _____

Do you drink caffeine? ☐Yes ☐No How much daily? _____

Do you smoke? ☐Yes ☐No How much daily? _____

For Our Female Clients

Are you using contraception? ☐Yes ☐No Currently pregnant or using nursing? ☐Yes ☐No

Trying to become pregnant? ☐Yes ☐No

Have you ever been treated for any of the following? (Check all that apply)

The highlighted areas would indicate a contraindication to not treat. You can speak in farther detail with your technician.

☐Cancer – You must be cancer – free from any treatment for 5 years to be eligible for treatment

☐AIDS ☐HIV Positive ☐Current Anemia ☐Blood clots ☐Seizures ☐Epilepsy

☐Diabetes ☐Keloid scars ☐Rheumatoid Arthritis ☐Lupus ☐Gout ☐Any auto immune

☐Pacemaker ☐Hearing Aid ☐Any Metal – This would exclude radio frequency based treatments

☐Bleeding Disorders ☐Current/Recent Pneumonia ☐Vascular Disease ☐Heart Disease

☐Cold sores ☐Problems with anesthesia ☐High Blood Pressure ☐Hepatitis ☐Herps

☐Ulcers ☐Nerve Disorders ☐Psoriasis ☐Eczema ☐Melasma

Print Name: _____

Sign: _____

Date: _____

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Patient Consent

I consent to and authorize Noor Laser Spa to preform treatments on me which may include, but are not limited to , Laser Hair Removal, IPL/Photo facial, Photo Rejuvenation, Tattoo Removal, 1064 Laser Facial, Alma Clear Lift, Laser and Radio Frequency Vien treatment, Cavitation Ultrasound, Fat Reduction, Coolpsculpting, Chemical Peel Skin, Cryolipolysis Treatment ,Lipo Laser Treatment,Tatto Removal, Laser and Radio Frequency Fractional Skin Resurfacing and Laser Skin Tightening.

The following are potential side effects that may occur with any laser treatment we offer here at Noor Laser Spa: Reddening, Mild Burning, Temporary Bruising or Blistering, Hyper -Pigmentation (Darkening) and Hypo - Pigmentation (Lightning). These conditions usually resolve within 3 to 6 months, but permanent color change, while rare, can occur. Avoiding sun exposure before and after the treatment reduces the risk of color change and must be avoided completely two weeks before and two weeks after all laser procedures.

Infection: although infection following treatment is unusual, bacterial, fungal and other viral infections can occur. Herpes simplex virus infections around the mouth can occur following the treatment. This applies to both individuals with past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infections occur, additional treatments or medical antibiotics may be necessary.

Bleeding: pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur additional treatment may be necessary.

Allergic reactions: in rare cases local allergies to tape and preservatives used in cosmetics or topical preparation have been reported. Systemic reactions, which are more serious may result from prescription medicines.

Compliance with the aftercare guidelines is crucial for healing, prevention of scarring and hyperpigmentation. Occasionally, unforeseen mechanical problems may occur, and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival at the office. Please be understanding if we cause you any inconvenience.

Acknowledgment: My questions regarding the procedure had been answered satisfactorily. I understand the procedure and except the risks. I hereby release Noor Laser Spa and their staff from all liabilities associated with the above indicated procedure.

As part of our policy, we will only discuss your appointment with you for privacy. Our staff will not be able to discuss, book, rebook, or make any changes or acknowledge any other client but you. This is to protect your privacy.

Thank you for taking the time to read and understand these policies. Your signature below represents an understanding of these policies and acceptance of financial responsibility.

Print Name: _____

Sign: _____ Date: _____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your services. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our and / or your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of new employees and/or medical students, and licensing board. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when we're ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Workers' Compensation: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures: Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law

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You may revoke permission at any time, in writing. Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices, unless specifically requested and annotated by Patient. Your request must state the specific restriction requested and to whom you want the restriction to apply. You have the right to request to receive confidential communications: You may request to receive information from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician and / or Noor Laser MedSpa's physician amend your protected health information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures: Any disclosures we have made, if any, of your protected health information: We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____

Patient name and signature: Date:

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CLIENT PHOTOGRAPY REALEASE CONSENT

Patient Name: _____, authorized Noor Laser Spa and staff representatives, to take photographs of my face and body for medical purposes for my patient care, marketing, literature and/or case presentations.

I UNDERSTAND THAT:

- Photographs are taken to capture treatment outcomes.
- They may be used for print, visual or electronic media including but not limited to, scientific presentations, website and for purposes of informing the medical marketing on behalf of the physician's practice.
- The images taken of me may be published by Noor Laser Spa and their agents and representatives.
- I will be not identified by name in any of the published materials.
- I have the right to revoke this authorization in writing at any time through written revocation to Noor Laser Spa.

I hereby release Noor Laser Spa and their agents and representatives from any and all claims and demands arising out of, or in conjunction with, the use of the photographs.

I certify that I have read this release carefully and fully understand its terms.

If under 18, guardian or parent must sign.

_____ (legal guardian or parent must sign)

Client Name: _____
Date: _____
Client Sign: _____

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IT IS A PLEASURE FOR NOOR LASER SPA TO OFFER YOU OUR SERVICES, THEREFORE IT IS IMPORTANT TO CONSIDER THE TIME AND RESPECT FOR BOTH THE STAFF AND OTHER CLIENTS'S TIME SINCE WE ATTEND BY APPOINTMENT.

- Noor Laser Spa requires 48 HOUR NOTICE to cancel or reschedule an appointment.

- For all appointments, in the event you miss a scheduled appointment and/or do not cancel your appointment prior to 48 hours, and/or an unapproved cancellation, it will be an extra charge of $30 Dollars 'No show Fee'.

- If you arrive more than fifteen minutes late for your schedule appointment, it will be considered a "NO SHOW". At the time, you will have to pay extra $30"NO SHOW" fee. Provision of services for late appointments will be at Noor Laser Spa.

- If a client has excessive no shows or last-minutes cancellations, Noor Laser Spa reserves the right to refuse further service regardless of contracts or other set appointments. Any monies paid will be forfeited or considered non-refundable.

- I agree and understand Noor Laser Spa cancellation policy.

Client Name (Print) :_____ Date: _____

Client Signature: _____ Date:_____

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CLIENT NAME: _____

EMAIL ADDRESS: _____

PHONE: _____

PACKAGE TYPE: _____ PRICE: _____

- I understand that if I am late (15 minutes or more) for my appointments, it will have to be re-scheduled.
- I understand that if I do not cancel an appointment at least 24 hours prior to the treatment time, or if I am more than 30 minutes late for an appointment, I will forfeit that treatment and it cannot be re-scheduled. No refunds given for treatments already preformed.

Treatment Record

TREATMENT #	DATE	NOTES

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Package Sale Agreement

The following is a description of the package you are purchasing today and the cost and payment provisions. Since our package sold at a significant discount from our regular prices, they are not refundable. In the event that you decide not to complete the package treatment, payment must still be made as scheduled below. Any unused portion of the package treatment, payment must still be there can be no cash or credit card refunds.

Package Includes: _____

Total Non-Refundable Cost: _____

Down Payment: Amount: _____ Date: _____

Future Payment:

1._Amount: _____ Date: _____ Amount: _____ Date: _____

2.-Amount: _____ Date: _____ Amount: _____ Date: _____

3.-Amount: _____ Date: _____ Amount: _____ Date: _____

4.-Amount: _____ Date: _____ Amount: _____ Date: _____

5.-Amount: _____ Date: _____ Amount: _____ Date: _____

6.-Amount: _____ Date: _____ Amount: _____ Date: _____

Credit Card # _____ Exp. Date _____ Zip Code_____

Texas Driver's License # _____

I understand that this is a binding contract between me and Noor Laser Spa and by my signature below I agree that I am responsible for the total cost shown on this from. I authorize Noor Laser Spa to charge me credit/debit card for the amounts listed under "Down Payment" and "Future Payments" on the dates indicated. I understand that there are no cash refunds and any unused portion of this package may only be converted to other spa services. I also agree to a $30 anytime I cancel or re-schedule my appointment with less than 48 hours' notice

Client Name: _____

Date: _____ Client Signature:_____