TIMELESS
SKIN SOLUTIONS

healthy skin at every age
TIMELESSSKINSOLUTIONS.COM
(614) 799-5100
31 South High Street
Dublin, OH 43017

patient consultation & medical history

Name: ______________________________ **Preferred/Nickname:** __________

Address: ______________________________ **Birthday:** _____ /_____ /________

City: ____________________ **State:** _____ **Zip:** ________

E-Mail: ______________________________
☐ **OK for email appointment reminder?**
☐ **OK for Medical/Schedule Info**
☐ **OK for email marketing message?**

Phone (primary) (   ) _____ - ________
☐ **OK for text appointment reminder?**
☐ **OK for Medical/Schedule Info**
☐ **OK for text marketing message?**

May we leave a message? Yes or No **May we leave a message with a person? Yes or No**

Legal Sex: ☐ **Female** ☐ **Male** **Do you identify as transgender or transsexual? Yes or No**

Referring Doctor/if applicable: ________________

Please check the items that concern you, and list their location:

Concerns:	Location:	Concerns:	Location:	Concerns:	Location:
☐ Acne	_________	☐ Veins/Capillaries	_________	☐ Scars	_________
☐ Pores	_________	☐ Skin Laxity	_________	☐ Neck	_________
☐ Bumps/papules	_________	☐ Brown/Red Spots	_________	☐ Chin/Jowl	_________
☐ Body Bulge	_________	☐ Redness	_________	☐ Hair	_________
☐ Lines/Wrinkles	_________	☐ Rosacea	_________		

Please describe any previous treatment you have had for these concerns:

____

____

Did you have any problems with these treatments? Yes or No

____

____

Have you tanned or used self-tanning products in the past 2 weeks? Yes or No

Do you use sunscreen? Yes or No SPF: __________

Pharmacy: ______________________________

Address: ______________________________ City: ____________________ Zip: ______________

Phone: (   ) _______ - ________

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Please circle YES or NO to the following conditions:

Neuromuscular problems:	Yes or No	Keloids:	Yes or No
Pregnant/lactating:	Yes or No	Cold sores/herpes:	Yes or No
Heart disease:	Yes or No	Skin cancer:	Yes or No
Permanent make-up/Tattoo:	Yes or No	Uveitis/Glaucoma	Yes or No
Respiratory problems:	Yes or No	Other (please specify):____________________	

Are you currently using Retinoids or Accutane? Yes or No ____________________

Are you using Vitamin E, Aspirin, or Coumadin? Yes or No ____________________

Please list all the medications and dosages (prescription & over-the-counter) you are currently taking:

____
____
____

Do you have any medical allergies? Yes or No

____
____
____

Do you have any food allergies or allergic conditions that we should be aware of? Yes or No

____
____
____

What is your heritage? (for laser purposes)

☐ Caucasian	☐ Hispanic	☐ Asian	☐ Mediterranean
☐ African American	☐ American Indian	☐ Indian	☐ Other (please specify):

What skin care products are you currently using?

____
____
____

Do you smoke? Yes or No

I certify that the above medical history information is accurate and correct. I am aware that the initial office visit with our medical staff is $60.00 due at the time of consultation. This fee will be deducted from the first procedure.

Patient Signature: ______________________________ Date: __________

MD Signature: ______________________________ Date: __________

Provider Signature: ______________________________ Date: __________

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Timeless Policies

Cancellation Policy

We want to thank you for your support and for choosing Timeless Skin Solutions as your care provider. We have established a cancellation policy in an effort to maintain a high quality of care for all of our patients.

To ensure that you and other patients receive the attention and consideration deserved, we are asking for advance notice for any cancellation or rescheduled appointment. We would like to have the option to offer schedule openings to another patient who needs to see the provider.

This serves as notification that:

- Appointments require a 24 hours cancellation notice, or there will be a charge of $25 for each 15 minutes of scheduled appointment time
- Ultherapy or CoolSculpting appointments require a five (5) day cancellation notice, or there will be a charge of $200

We thank you in advance for your cooperation. We will continue to do our best to stay on time for your appointments as we know that your time is also valuable. In addition, if you have allowed Timeless Skin Solutions to send you email, we will send email reminders prior to scheduled appointment(s).

____
Patient Initials

Product Return Policy

ALL SALES FINAL
I understand products returned within sixty (60) days unopened will be credited to my account.

____
Patient Initials

Account Credit Policy

I understand if I have any credit on my account or pre-paid package I have two years to use these funds and or services.

____
Patient Initials

I have read and acknowledge the above; Cancellation Policy, Product Return Policy and Account Credit Policy.

______________________________	______________________________________	______________
Print Patient Name	Patient Signature	Date

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Carol L. Clinton, M.D., all medical professionals & staff

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _______________________________ Address: _______________________________________

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities and healthcare operations.

Notice of privacy practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Contact Person: Carol Clinton, MD **Telephone**: (614) 799-5100
Email: drcarol@timelessskinsolutions.com **Address**: 31 South High Street, Dublin, OH 43017

Signature
I, ____, have had full opportunity to read and consider the contents of this consent form and have received a copy of the office's Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: ____ Date:_________________

If a personal representative on behalf of the patient signs this consent, complete the following:

Personal Representative's Name: ____

Relationship to the Patient:____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation by signing the Revocation of Consent. This form is available upon request.

TIMELESS SKIN SOLUTIONS, CL, LLC - FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

______ Individual refused to sign
______ Communication barriers prohibited obtaining the acknowledgement
______ An emergency situation prevented us from obtaining acknowledgement
______ Other

Include Consent in the patient's chart

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Timeless Skin Solutions, CL, LLC
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NOTICE OF PRIVACY PRACTICES

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

A. Introduction: This notice will tell you about how I handle information about you. It tells how I use this information, how I share it with other professionals, and how you can see it. I want you to know all of this so that you can make the best decisions for yourself. I am also required to tell you about this because of the privacy regulations of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Because this law and the laws of this state are very complicated, I have simplified some parts. If you have any questions or want to know more about anything in this Notice, please let me know.

B. What is your medical information?: Each time you visit this office or any other "healthcare provider", information is collected about you. This information may include information about your past, present, or future health or conditions, or the treatment or other services you got from me or from others, or about payment for healthcare. The information I collect from you is called, in the law **PHI** which stands for **Protected Health Information.** This information goes into your medical or healthcare record here in this office. This information is likely to include: your history, reasons you came for treatment, diagnoses, a treatment plan, progress notes, records from others who treated you or evaluated you, information about medications you took or are taking, legal matters and billing and insurance information. This list is just to give you an idea of what is included. I use this information for the purpose of planning your care and treatment, deciding how well the treatment is working, and talking with other healthcare professionals who are also treating you such as your family doctor.
When you understand what is in your record and what it is used for you can make better decisions about who, when, why, and if others should have this information.
Although your health record is the physical property of the healthcare practitioner or facility that collected it, the information belongs to you. You can inspect, read or review it. If you want a copy I can make one for you but may charge you for the costs of copying (and mailing if you want it mailed to you). In some very unusual situations you cannot see all of what is in your records. If you find anything in your records that you think is incorrect or something important is missing, you can ask me to amend your record although I may not agree to do that. Please ask me if you need more information about this.

C. Privacy and the Laws: The HIPAA law requires me to keep your PHI private and to give you this notice of my legal duties and privacy practices which is called the **Notice of Privacy Practices** or **NPP**. I will obey the rules of this notice as long it is in effect but if I change the NPP I will post the new Notice in my office where everyone can see. You or anyone else can also get a copy from me. In the event of an unauthorized disclosure of your PHI, I will notify you about it immediately.

D. How your protected health information can be used and shared: The law gives you rights to know about your PHI, how it is used and to have a say in how it is disclosed. I use and disclose PHI for several reasons.

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1. Uses and disclosure of PHI in healthcare with your consent:

After you have read this Notice you will be asked to sign a separate Consent form regarding your PHI. In almost all cases I intend to use your PHI here, arrange for payment for my services, or some other business functions called healthcare operations. Together these routine purposes are called **TPO** and the Consent form allows me to use and disclose your PHI for TPO.
For Treatment: I use your medical information to provide you with medical treatment or services.
For Payment: I may use your information to bill you or others to be paid for the treatment I provide to you. I may contact your insurance company to check on exactly what your insurance covers. I may have to tell them about your diagnoses, what treatments you have received, and what I expect as I treat you. I will need to tell them about when we met, your progress, and other similar things.
For Healthcare Operations: There are some other ways I may use or disclose your PHI which is called healthcare operations. If I do, your name and identity will be removed from what is used. Examples of this include utilization review.
Other uses in healthcare include appointment reminders and scheduling. If you want me to call or write to you only at your home or your work or prefer some other way to reach you, I usually can arrange that. Just tell me.

2. Uses and disclosures requiring your Authorization:

If I want to use your information for any purpose besides the TPO or those I described above, I need your permission on an Authorization form. If you do authorize me to use or disclose your PHI, you can revoke (cancel) that permission, in writing, at any time. After that time I will not use or disclose your information for the purposes that I agreed to. Of course, I cannot take back any information I had already disclosed with your permission or that I had used in my office. I may find it beneficial to talk with other healthcare providers who are treating you or treated you in the past. In that case I will ask you to sign an authorization form to do so. Often this is helpful in formulating a treatment plan for you.

3. Uses and disclosures of PHI from health records Not requiring consent or authorization:

The law requires me to report suspected child or elder abuse. When ordered by the court for a lawsuit or a legal proceeding. If I believe there is a serious threat to your health or safety or that of another person or the public, I can disclose some of your PHI > I will only do this to persons who can prevent the danger.

E. If you have any questions about this notice or problems, please let me know.