TIMELESS
SKIN SOLUTIONS

healthy skin at every age
TIMELESSSKINSOLUTIONS.COM
(614) 799-5100
31 South High Street, Dublin, OH 43017
150 East Main Street, New Albany, OH 43054

patient consultation & medical history

Name: _____ **Preferred/Nickname:** _____

Address: _____ **Birthday:** ____ /____ /_____

City: _____ **State:** ____ **Zip:** _____

E-Mail: _____ **Phone (primary)** ( ) _____ - _____

How did you hear about us? _____

Referring Doctor/if applicable: _____

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

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	_____	☐ painful intercourse	
☐ leaking urine		☐ vaginal dryness			

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: _____ Phone: ( ) _____ - _____

Address: _____ City: _____ Zip: _____

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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/NP Signature: _____ Date: _____

Provider Signature: _____ Date: _____

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Consent to Communicate

Patient: _____ DOB: _____

Please mark the ways that you consent to us communicating with you:

Method (check all that apply)	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☒ Email Communication	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Info				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☒ Text Message Communication			☐	-
☐ Text Appointment Reminders				
☐ Text Medical Info				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	Phone	Relationship	Emergency Contact?	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

If you would like for anyone else to have the ability to call and schedule appointments or have access to your protected health information, please list them:

Name	Phone	Relationship	Emergency Contact?	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Responsible Party Name: _____ **Phone:** _____
(parent or guardian if under 18)

Signature: _____

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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