CHAPIN
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CLIENT SKINCARE QUESTIONNAIRE

NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

ADDRESS: _____

HOME PHONE: _____ **WORK:** _____ **CELL:** _____

EMAIL: _____ **SS#:** _____

REFERRED BY: _____ **DO YOU SMOKE: YES NO**
IF YES HOW MUCH? _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING ASPIRIN: _____

_____

ARE YOU PREGNANT, MENSTRUATING, TAKING HORMONES/BIRTH CONTROL? YES NO
IF YES, PLEASE EXPLAIN: _____

_____

_____

LIST ANY ALLERGIES, INCLUDING MEDICATIONS, TOPICAL CREAMS OR OINTMENTS: _____

_____

ARE YOU UNDER A DOCTOR'S CARE: YES NO **IF YES, FOR WHAT ?** _____

_____

_____

HAVE YOU EVER HAD HERPES, HIVES, FEVER BLISTERS, COLD SORES, OR KELOIDS?:YES NO

LIST PRIOR SURGERIES, INCLUDING COSMETIC: _____

_____

DO YOU SPEND TIME IN THE SUN (SPORTS, GARDENING, ETC)? YES NO
DO YOU USE SUNBLOCK REGULARLY? YES NO
WHAT LEVEL SPF? _____

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HAVE YOU EVER USED RETIN A, RENOVA, OR TOPICAL VITAMIN C? YES NO
WHICH PRODUCTS?WHEN _____ _____

HAVE YOU EVER USED SKIN LIGHTENERS OR PRESCRIPTION ACNE PREP: YES NO

HAVE YOU EVER HAD A CHEMICAL PEEL? YES NO

DO YOU HAVE HIV/AIDS? YES NO **DO YOU HAVE HEPATITIS? YES NO**

DO YOU HAVE DIABETES? YES NO **DO YOU HAVE AN AUTOIMMUNE CONDITION? YES NO**

WHAT SKIN CONCERNS/PROBLEM DO YOU HAVE? _____

_____

DO YOU CONSIDER YOUR SKIN SENSITIVE? YES NO

IS YOUR SKIN: **DRY** **OILY** **NORMAL** **COMBINATION**

DO YOU HAVE A SUNTAN? YES NO **ARE YOU ALLERGIC TO LATEX? YES NO**

LIST ALL PRODUCTS YOU ARE USING: _____

_____

_____

_____

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CONSENT AND RELEASE

I acknowledge that the practice of medical skin care including hair removal, facial rejuvenation, tattoo removal is not an exact science. I acknowledge that no specific guarantees can or have been made concerning the expected result. I understand that some clients experience more change and improvement than others. In most cases multiple treatments are required in order to realize a difference.

I also understand the following risk and hazards may occur in connection with any particular treatment, including but not limited to: unsatisfactory results, poor healing, discomfort, redness, blistering, nerve damage, scarring and infection, changes in the skin's pigment, pain, bruising, burns and swelling. Laser hair removal provides a permanent reduction in hair growth.

I understand and agree that sun exposure; the use of tanning lamps (within 4 weeks) and/or not adhering to the post care instructions provided to me might increase my chance of complications.

With complete understanding and agreement of the above, I authorize _____
to perform the above to perform the above-mentioned treatment on me. I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. I also agree to hold harmless and release from any liability Medical Aesthetician, Certified Aesthetic Nurse Specialists, the Chapin Aesthetics Center, or an of it's officers, directors, employees or trainers for any condition or result, known or unknown, which may arise as a result of any treatment that I receive.

_____ _____

Patient Signature Date

_____

Print Name

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO FAMILY & FRIENDS

I hereby authorize Chapin Aesthetics Center, Scott D. Chapin, M.D. Plastic & Reconstructive Surgery, P.C. Chapin Aesthetics to release my patient information described below to:

_____ All of my family members
_____ Spouse
_____ Mother
_____ Father
_____ Children:
_____ Other family members: _____
_____ The following person: _____
_____ _____

DOCUMENTS/INFORMATION TO BE RELEASED:

_____ Appointment dates/times relating to today's treatment.
_____ Biopsy/test results relating to today's treatment.
_____ Other. Please indicate: _____
_____ You have my permission to leave messages regarding my treatment on my work and home answering machine.

PURPOSE OF DISCLOSURE (explain or indicate "at the request of the individual"):

_____ At the request of the individual.Other _____ _____

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPPA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the expectations to the right to revoke and a description of how I may revoke this Authorization is set forth in the Practice's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature and that I should send it to:

The Chapin Aesthetic Center
Scott D. Chapin, M.D. Plastic & Reconstructive Surgery, P.C.
253 West State Street
Doylestown, PA 18901

I understand that I am not required to sign this Authorization and that the Practice may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclose by the Recipient listed above and, in that case, will no longer be protected by HIPPA.

It is my responsibility to notify Dr. Chapin's office of any changes.

I hereby acknowledge receipt of a copy of this Authorization

_____
Signature of Individual or Personal Representative

_____
Description of Personal Representative's Authority

_____
Date of Authorization

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF CHAPIN AESTHETICS CENTER, SCOTT D. CHAPIN, M.D. PLASTIC & RECONSTRUCTIVE SURGERY, P.C.'S NOTICE OF PRIVACY PRACTICES

By signing this acknowledgement, I am acknowledging that Scott D. Chapin, M.D. Plastic & Reconstructive Surgery, P.C. Chapin Aesthetics provided to me in information its "Notice of Privacy Practices."

I was given the opportunity to ask questions about the Practice's privacy practices and my questions were answered.

I received a copy of the Practice's "Notify of Privacy Practices."

Signed by:

_____	_____
Description of Personal Representative's Authority	Relationship to Patient
_____	_____
Patient's Name (print)	Date
_____	_____
Witness	Date

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SCOTT D. CHAPIN M.D., F.A.C.S

CANCELLATION POLICY

Chapin Aesthetics strives to render excellent medical care to you and the rest of our patients.
The cancellation policy enables us to better utilize available appointments for our patients in need of care.

Cancellation of an Appointment
If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance; certainly calling earlier in the day is most appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to a timely service.

How to Cancel Your Appointment
To cancel appointments, please call 267.880.0810. If you do reach the receptionist you may leave a detailed message on the voicemail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

No-Show Policy
Clients who miss appointment without canceling at least 24 hours in advance are considered “no-shows.” A “no-show” will result in a fee of $100 billed to the patients account.

Confirmation Calls
As as a courtesy we do make confirmation calls for appointments. Please provide us with accurate information so that you may be contacted in acceptable manner. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have.

Thank you from Our Staff at Chapin Aesthetics