FLORIDA
FACE AND BODY

PLEASE PRINT CLEARLY

Last Name _____First Name _____ MI _____

Local Address _____

City _____ State _____ Zip Code_____

Home # _____ Cell#_____ Work # _____

Email _____

Date of Birth _____ Age _____ Sex ☐ M ☐ F

Primary Care Physician _____ Phone # _____

Are you a year round resident? ☐ Yes ☐ No

Northern Home Address _____

City _____ State _____Zip _____

Northern Home Phone # _____

Emergency Contact or Next of Kin

Name _____

Relationship _____

Home # _____ Cell#_____ Work # _____

Referral Information

Whom may we thank for referring you to our office?

_____

☐My Optometrist ☐ My Primary Care Physician ☐ Website ☐ Friend or Patient
☐Billboard ☐ Facebook ☐ Real Self ☐ Instagram ☐ Our Eye Clinic ☐ Google

FLORIDA
FACE AND BODY

Score

Skin Type Assessment

Questions	1	2	3	4	5	
What are the color of your eyes?	Light Blue, Gray or Green	Blue, gray or green	Blue	Dark Brown	Brownish Black	
What is the natural color of your hair?	Red	Blonde	Dark Blonde or Light Brown	Dark Brown	Black	
What is the color of your skin? (Non-exposed areas)	Redish	Very Pale	Pale w/ Beige Tint	Light Brown	Dark Brown	
Do you have freckles on non-exposed areas?	Many	Several	Few	Less than Few	None	
					Total Score for Genetic Predisposition	
What happens when you stay in the sun too long?	Painful, redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rare burns	Never had burns	
To what degree do you tan?	Hardly or not at all	Light colored tan	Reasonably tan	Tan very easy	Get darker quick	
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never a problem	
					Total Score for Sun Exposure	
When did you last expose your body to the sun? (or artificial sun lamps or creams)	More than 3 months ago	2-3 months ago	1-2 months ago	Les than a month ago	Less than 2 weeks	
Did you expose the treatment area to the sun?	Never	Hardly ever	Sometimes	Often	Always	
					Total Score for Tanning Habits	
					Sum of all the Scores	

Name of Patient (please print)

Signature of Patient

Date

FLORIDA
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HIPAA AUTHORIZATION
FOR USE OR DISCLOSURE
OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient: _____

Date of Birth: _____

I. My Authorization

I authorize the Eye Clinic of Florida to disclose my health information, either in person or over the phone, to the person(s) listed below:

Name:_____ Phone:_____ Relation:_____
Name:_____ Phone:_____ Relation:_____
Name:_____ Phone:_____ Relation:_____

Reviewed - No Changes: (Signature Required)	Date

II. My Rights

I understand that I have the right to revoke this authorization, by certified letter, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

FLORIDA
FACE AND BODY

If the patient is a minor or unable to sign please complete the following:

- ❑ Patient is a minor: _____ years of age
- ❑ Patient is unable to sign because:
  _____

Signature of Authorized Representative: _____ Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

- ❑ Parent
- ❑ Legal Guardian
- ❑ Court Order
- ❑ Other:
  _____

III. Additional Consent for Certain Conditions

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

- ❑ I consent to have the above information released.
- ❑ I do not consent to have the above information released.

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

- ❑ I consent to have the above information released.
- ❑ I do not consent to have the above information released.

*Signature of Patient or Authorized Representative:*_____

Date: _____ *Time:* _____

YOU CAN REQUEST A COPY OF OUR HIPAA PRIVACY AGREEMENT AT CHECK-IN.

FLORIDA
FACE AND BODY

INFORMED CONSENT FOR LASER & LIGHT BASED TREATMENTS

1. I hereby authorize Florida Face and Body's certified personnel to perform the following procedures or treatment(s):

   __ Laser hair removal __Rosacea __Acne Sunspot removal __Blepharitis __Anti-aging facial

2. I recognize that during the course of the procedure and medical treatment, unforeseen conditions may need different procedures than those listed above. I therefore authorize Tampa Laser Hair Removal's physician, technicians, and or assistants to perform such other procedures that are in the exercise of his or her professional judgement necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known by our physician at the time the treatment is performed.

3. I consent to the administration of numbing agent considered necessary or advisable. I understand that all forms of numbing cream involve risk and the possibility of complications.

4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained and a series of treatments is advised to obtain optimum results.

5. I certify that the above treatment that I will be undergoing has been explained to me in a way that I understand including the risks and complications that may be involved.

I CONSENT TO THE TREATMENT AND I AM SATISFIED WITH THE EXPLANATION.

Patient Signature: _____ Date: _____

FLORIDA
FACE AND BODY

INFORMED CONSENT – LASER & LIGHT BASED TREATMENT PROCEDURES

Thank you for choosing Florida Face and Body where we pride ourselves on offering quality and comfort during your time with us!

This is an informed consent document which has been prepared to help inform you about laser treatments including: the treatment plan, precautions, pre care & post care.

Laser and light based treatments have been used for many years to treat conditions such as wrinkles, sun damaged skin, unwanted hair, unsightly veins, acne scars, and similar conditions. Based on your skin conditions and or concerns our qualified technician will evaluate your skin and set up a treatment plan accordingly. To achieve optimum results we always recommend a series of treatments.

There are both risks, unknown risks and complications associated with all laser treatment procedures of the skin. Risk involve both items that specifically relate to the use of laser energy as a form of surgical therapy and the patients adherence to post care instructions. Although the majority of patients do not experience complications, we advise that you speak with your physician first if you have any questions or concerns. Be aware that laser/ light based treatments can cause Infection, scarring, burns, skin damage, redness, swelling or discomfort.

To reduce your risk we advise that you follow our pre & post care instructions. Patient follow through following a laser skin treatment procedure is important. Post-operative instructions concerning appropriate restriction of activity, and use of sun protection need to be followed in order to avoid potential complications, and or unsatisfactory results.

There are many variable conditions which influence the long term result of laser skin treatments. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with the procedures we offer. Other complications and risks can occur but are even more uncommon. Should complications occur, procedures, or other treatments may be necessary. Results may vary due to the initial condition of your skin and the number of treatments you obtain. We advocate an improvement in your skins condition rather than permanent results, which may only be achieved through ongoing treatments. Although excellent results are expected, there is no guarantee or warranty expressed or implied for the results that may be obtained.

Patient Signature: _____ Date: _____

FLORIDA
FACE AND BODY

Please read and initial each statement. Complete, underline or circle individual selection accordingly.

	Initials
I authorize Dr. Mahootchi and his certified technicians to perform IPL™ on me in an effort to improve Dyschromia / Hyperpigmentation / Hair Reduction / PWS /Birthmarks / Moles or Tumor growths / Rosacea / Spider veins/ Other: _____	
I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility.	
I understand the below list of short-term effects and agree to follow matching guidelines: • Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring • Discomfort – during the procedure, I might experience a sensation similar to rubber band snap which degree will vary per my skin condition and area sensitivity but that does not last long. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams • Reddening and swelling – severity and duration depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or inflammatory creams • Bruising may rarely occur and may last up to 2 weeks	
I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications.	
The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered.	
Pre and post-care instructions have been discussed and are completely clear to me.	
I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required.	
I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record.	
I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record.	

FLORIDA
FACE AND BODY

Natural or artificial sun exposure in the past 3-4 weeks pre-op or following 3-4 weeks post-op plan?	NO	YES
Use of self-tanners or tan enhancer caps within the past 3-4 weeks pre-op plan?	NO	YES
Photosensitive herbal preparations (St. John's Wort, Gingko Biloba, etc.) or aroma therapy (essential oils)?	NO	YES
Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of Systematic Lupus, Erythematous or Porphyria?	NO	YES
Pregnant or possibility of pregnancy, postpartum, or nursing	NO	YES
Inflammatory skin conditions (dermatitis, active acne, etc.)?	NO	YES
Presence or history of active cold sores or herpes complex virus?	NO	YES
HIV?	NO	YES
Active cancer (currently on chemotherapy or radiation)?	NO	YES
Previous skin cancer?	NO	YES
Medical history of keloids?	NO	YES
Intake of isotretinoin within the past year?	NO	YES
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)?	NO	YES
Any known allergy?	NO	YES
Any tattoo and/or pigmented lesion on requested treatment area that should be protected?	NO	YES
Hormonal or endocrine disorders (PCOS or uncontrolled diabetes)?	NO	YES
Previous hair removal procedures on requested treatment area (other than IPL, Laser, Wax, electrolysis, etc.)?	NO	YES: What/When?
Any observed modicifcation (color, size, tecture and border) on lesion to be treated?	NO	YES
Any hair on requested treatment area that should not be removed?	NO	YES
Lesion onset?	NO	YES: Age of Lesion
Previous skin procedures on requested treatment area (BOTOX, fillers, peels, etc.)?	NO	YES: What/When?
Intake of asprin or anti-coagulants?	NO	YES
Easy bruising?	NO	YES
Swollen legs or pain after long standing/sitting?	NO	YES
Previous vein surgery on requested treatment area (sclerotherapy, stripping etc.)?	NO	YES: What/When?
List of additional current medication taken		

My signature certifies that I have duly read and understood the content of this informed consent and gave the accurate information as to my health conditions. I hereby freely consent to laser hair removal and/or laser skin treatments.

_____
Name of Patient (please print)

_____ _____
Signature of Patient Date

FLORIDA
FACE AND BODY

TREATMENT PLAN

In the case of Laser hair removal expect 8-10 treatments scheduled 4-6 weeks apart to achieve optimum results.

In the case of Light based treatments expect 3 treatments scheduled 4 weeks apart to obtain optimal results.

CARE OF TREATED AREA

In the case of laser or light based treatments use of cold packs are allowed periodically following the treatment to reduce any swelling. Apply aftercare/ healing products as prescribed by your technician.

WHAT TO EXPECT

In the case of Laser hair removal 7-30 days after treatment, shedding of the surface hair may occur and this appears as new hair growth. This is NOT new hair growth. You can gently cleanse area during this time using sensitive skin cleansers. Between treatments you may continue to remove hair by shaving only. Avoid harsh topical products such as retinols and glycolic acid products for one week after.

In the case of intense pulse light treatment(s) you may experience significant swelling, this can last for a few days. Some redness may be present.

PRECAUTIONS

In the case of laser or light based treatment(s) avoid hot showers, sweaty workouts, tight clothing on treated areas, sun exposure, and chlorinated pools 24 hours post treatment. We advise clients to wear a 30+ sunblock on exposed areas.

Patient Signature: _____ Date: _____

FLORIDA
FACE AND BODY

Pre & Post Care Instructions for
Laser Hair Removal Treatment

BEFORE YOUR APPOINTMENT

If you have had a history of perioral herpes, prophylactic antiviral therapy may be started the day before treatment and continued one week after treatment

- Avoid sun exposure and tanning beds for at least 4 weeks prior to your treatment.
- Tanning creams (self-tanner) should be avoided for at least 2 weeks.
- Inform the technician if you have taken Accutane(oral acne medication) in the past year.
- Do not tweeze, wax or epilate the area being treated for approximately 4-6 weeks prior or during treatment course.
- The night before treatment thoroughly shave all areas to be treated unless instructed otherwise; skin must be clean and free of all hair.
- If you start a course of strong Antibiotics please schedule your appointment a week after you have completed your antibiotics.

THE DAY OF YOUR APPOINTMENT

- If possible, arrive without creams or make-up on the treatment area. Otherwise please arrive 10 minutes prior to your appointment in order to clean the skin
- Allow 20 minutes to 1 hour for your appointment depending on the size of the treatment area.

LASER HAIR REMOVAL TREATMENT: WHAT TO DO AFTER YOUR TREATMENT

- Shortly after treatment, the treated areas may appear as swollen red bumps. Cold compresses are available; you may continue to apply these compresses/ Aloe Vera Gel for your comfort over the next 24 hours. Rarely, minor epidermal blistering may occur in which case triple antibiotic cream may be applied. If this should happen, please contact our office and ask to speak with your Laser Specialist.
- Treated hairs will appear as small black dots, stubble or as if still growing. You will naturally expel these treated hairs over the next 10 – 14 days.
- Avoid irritating the treated area with aggressive exfoliation, such as with a bath puff or scrub. Do not pick at or pluck/tweeze these residual hairs. You may shave these hairs.
- Treated areas should either be kept out of direct sun light, or sun protection is imperative after any skin laser treatment. A broad spectrum UVA/UVB sunscreen (SPF 30 or greater) should be worn on treated areas each day for 4-6 weeks post treatment

Patient Signature: _____ Date: _____

FLORIDA
FACE AND BODY

Cancellation Policy

If you need to cancel and appointment, please do so at least 24 hours in advance by calling (813) 640-0085.

Any patient who misses an appointment without 24 hours advance notice will incur a charge of one session.

Any patient who cancels an appointment within the 24-hour limit will be charged $50.

Any patient who misses more than three appointments are subject to dismissal from the practice.

Waivers to this policy are granted at the sole discretion of Tampa Laser Hair Removal. By signing below, I acknowledge awareness of this cancelation policy.

_____
Name of Patient (please print)

_____ _____
Signature of Patient Date