



First Name: _____ Last Name: _____ Middle: _____

Address: _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____
 Which number may we use to leave messages or communicate with you? _____

Social Security Number _____ Date of Birth _____ Occupation _____

Email Address (strictly for CC promotions/discounts) _____

Reason for your visit today? _____

How did you hear about Carolina Cosmetics? _____

Please list all medications you are currently taking including aspirin, vitamins, herbs and/or herbal tonics.

Medication & Dosage	Reason	Medication & Dosage	Reason

Are you allergic to any medications or non-medical items? Please list below.

Allergy	Reaction	Allergy	Reaction

Do you or have you ever had any of the following conditions or treatments? (Please circle "Yes" or "No")

Acne	Yes	No	Diabetes	Yes	No	Thyroid Problem	Yes	No
Dermatitis	Yes	No	Eczema	Yes	No	High Blood Pressure	Yes	No
Fever Blisters	Yes	No	Skin Cancer	Yes	No	Laser Resurfacing	Yes	No
Hormonal	Yes	No	Cancer	Yes	No	Are you pregnant?	Yes	No
Waxing	Yes	No	Chemical Peel	Yes	No	Are you nursing?	Yes	No

History of blistering sunburns _____ Do you use sunscreen? _____ SPF _____

Sun exposure time: Occupational _____ hours/week Recreational _____ hours/week

Have you ever used Retin A? _____ What strength? _____ How long? _____ Reaction _____

Facial surgery? _____ Type _____ Date _____

Major health problem? _____ Diagnosis _____ Date _____

Emergency Contact:

Name _____ Phone Number _____ Relation _____

I acknowledge receipt of the Practice's Notice of Privacy Practices (found on pgs. 2-3). I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature _____

Date _____

Congratulations and thank you for choosing Carolina Cosmetics to provide your Scientific Skin, Laser and Aesthetic therapies. Payment is respectfully requested when services are rendered. There are **no refunds** for any services that go unused. Packages, gift certificates and credits must be completed within 18 months from the date of purchase or the remaining value is forfeited. Results are not guaranteed and there will be no refunds for any services' perceived complications from treatment. Exceptions may be considered on a case by case basis.

Signature _____

Date _____

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.

Understanding your medical record/health Information

As your healthcare provider, we will maintain a record of your visit that contains your symptoms, reports of examination and test results, diagnoses, treatments, correspondence with other providers and plans for future care or treatment.

Your Health Information Rights

Your health record is the physical property of this practice, however, the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Officer of the practice of your requests for any of these actions:

- A. Request Restrictions: you have a right to request restrictions on the use of your information.
- B. Obtain a paper copy of this notice: You have a right to receive a paper copy of this Notice.
- C. Inspect and copy: you have a right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage, and supplies used.
- D. Amend: You have the right to request that we amend your health information.
- E. Obtain and Account of Disclosures: You have the right to request and accounting of certain disclosures of information that have been made about you. This listing includes disclosures of your information for other than treatment, payment, or healthcare purposes and is within a specified period of up to six years. The first listing of disclosures is provided as a complimentary service to you, but you may be charged a reasonable fee for additional requests made within a twelve-month period.
- F. Request communications of your health information: you have the right to request that you receive communications regarding your information in a certain manner or at a certain location.
- G. Revoke your authorization for Disclosure: you have the right to revoke an authorization for disclosure of information that was previously given.

Our Responsibilities

Our practice is required to:

- A. Confidentiality---maintain the privacy of your health information.
- B. Provide a copy of this notice---We will provide you with a copy of this notice of our legal duties and privacy practices with respect to the information we collect and maintain about you.
- C. Abide by the terms of this notice
- D. Unable to restrict---We will notify you if we are unable to agree to a requested restriction of your information.
- E. Provide alternative means or alternative locations---We will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our privacy practices and to make new provisions effective for all protected health information we keep. Should your information practices change, we will notify you of these changes when you return to our office. We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information

- A. If you have a question or would like additional information, you may contact our privacy officer (office manager).
- B. If you have a concern about the privacy of your information, you may contact our privacy officer. Your concerns will be responded to by our practice, but you may also file a complaint with the secretary of health and human services in the U.S. office of Civil Rights. The privacy officer will supply you with the information about this procedure.

Examples of Disclosures of Information

A. Treatment

1. We will use your health information for treatment purposes. An example, information given to a nurse or physician will be recorded in your health record and used to determine the best treatment for you. Members of the healthcare teams will document your treatment goals, actions taken and clinical observations.
2. We will provide your healthcare providers with copies of various reports that will help them to treat you for any subsequent conditions that may arise.

B. Payment— A bill may be sent to you or third-party payer. The information on or accompanying the bill may include information that identifies you, your diagnoses, treatments, and supplies used.

C. Healthcare Operations---The physicians and members of your healthcare team may use the information to evaluate the quality of care you received as well as the care received by others similar to you. This information will be used to improve the effectiveness of healthcare operations and services we provide.

D. Business Associates---There are some services provided through contracts with business associates. As an example, we contract with a company that provides information services for the computer system we operate. When these services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associate must appropriately safeguard your information.

- E. **Notification**---We may disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your general condition.
- F. **Communication with family**---We will use good judgment in disclosing to a family member, or any other person you identify, health information relevant to that person's involvement in your care.
- G. **Research**---We will disclose only limited information to approved researchers that participate in research approved by our institutional review board. We will obtain a written authorization from you to disclose information for other research purposes.
- H. **Funeral Directors**---We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.
- I. **Organ Donation**---If you are an organ donor, we may disclose your information to organization that help procure, bank or transport organs for tissue donation and transplantation purposes.
- J. **Marketing**--- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- K. **Fund Raising**---We may contact you as part of a fund-raising effort.
- L. **Food and Drug Administration**---We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable product recalls, repairs or replacements.
- M. **Worker's Compensation**--- In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation.
- N. **Public Health**---Under South Carolina law, we may disclose your health information to the health department in order to prevent or control disease, injury, or disability.
- O. **Correctional Institution**--- If you are an inmate of a correctional institution, we may disclose to the institution or its agents health information that is needed for your health or the health and safety of other individuals.
- P. **Law Enforcement**---We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
- Q. **Health Investigation**---Federal and state laws make provisions for your health information to be released to appropriate health authorities provided that a member of our staff or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise endangered one or more patients, workers or the public.
- R. **Other Disclosures**---All other uses and disclosures of your information will only be made with your written authorization. If you have authorized us to use or disclose information about you, you may revoke this authorization at any time.

Acknowledgement of receipt of privacy practices

I understand that I may obtain a copy of the Notice of Privacy Practices. This Notice has been issued and considered effective on the date signed. We will keep this signed form on file for minimum of six (6) years.