



Name: _____

Karma Wellness Center
120 N Main St Suite 400
New City, NY 10956
845-825-3362
www.KarmaWC.com

Patient Consent Form

PLEASE COMPLETE ALL 4 PAGES

Patient: _____ DOB: _____

Address _____ City _____ NY NJ PA CT ZIP _____

Telephone _____ Email: _____

The following points of information have been specifically discussed and I have had the opportunity to ask any questions concerning this information. ***if you are using a groupon be aware that the groupon is only valid for new patients and that a 24 hr cancellation or no show counts toward your package or a \$25 no show fee. Packages may be brought online for similar pricing as groupon. Groupons and PACKAGES ARE NON-REFUNDABLE!***

I am aware of this policy: (sign) _____ (print) _____

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Aesthetics Consult Record

Patient Name: _____

Date: _____

Medical and Surgical History

Age: ____ Weight: ____ lbs. Height: ____

Gender: M F Race: _____

Active Severe or Cystic Facial Acne* YES NO
 Open facial wound or lesion* YES NO
 Metal stents in the treatment area** YES NO
 Implanted electrical devices** YES NO
 Pregnant or lactating*** YES NO
 Migraines*** YES NO
 Bell's palsy*** YES NO
 Hemorrhagic or bleeding disorders*** YES NO

Mechanical or other implants in the treatment area** YES NO
 Active or local skin disease that may alter wound healing*** YES NO
 Autoimmune Disease*** YES NO
 Epilepsy*** YES NO
 Herpes or Cold sores*** YES NO
 Diabetes *** YES NO

Tattoos - YOU ARE RESPONSIBLE TO MAKE PRACTITIONER AWARE AND TO COVER IT BEFORE EVERY SESSION

Tattoo: Yes No

List any chronic illness: _____

Undergone the following cosmetic procedures in the brow or lower face and neck area:

Facial skin tightening procedure treatment within the last 1 year..... YES NO

Treatment name: _____ Location treated: _____ Date of last treatment _____

Filler (i.e. Juvederm® or Sculptra®) within the last 3-6 months..... YES NO

Product name: _____ Location treated: _____ Date of last treatment _____

Neurotoxin (i.e. Botox® or Dysport®) within the last 3-6 months..... YES NO

Product name: _____ Location treated: _____ Date of last treatment _____

Ablative resurfacing laser treatment YES NO

Treatment name: _____ Location treated: _____ Date of last treatment _____

Non - Ablative resurfacing laser treatment YES NO

Treatment name: _____ Location treated: _____ Date of last treatment _____

Dermabrasion or deep facial peels..... YES NO

Treatment name: _____ Location treated: _____ Date of last treatment _____

Lipoplasty in the face or neck regions..... YES NO

Treatment name: _____ Location treated: _____ Date of last treatment _____

Facelift or blepharoplasty or brow lift..... YES NO

Treatment name: _____ Location treated: _____ Date of last treatment _____

Are you currently taking the following prescription medications:

Accutane within the last 12 months..... YES NO

Anticoagulants or antiplatelet drugs..... YES NO

Immunosuppressant drugs..... YES NO

List all medications or supplements below. Be sure to include all prescription or non-prescription medications

If you are not taking any medications or supplements please check here:

Medication	Disease/Reason	Dose	Frequency	Date started	Date last taken

Allergies: NKDA or list _____

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Aesthetics Consult Record

Self-Exam

As every patient is different, the clinical factors listed below are intended to assist your clinician in forecasting your clinical response to Ultherapy. Please score each clinical factor listed below. Upon examination of your responses, your physician will discuss your options for achieving optimal results.

Clinical Response Factors: Check the appropriate answer below

Age: <35 y/o 35-49 y/o 50-64 y/o 65+ y/o

Smoking History: Never smoked Ex-smoker Light smoker Heavy smoker

Health: No health issues Minor health issues Chronic health issues

Sun exposure: Never use sun screen Occasionally use sun screen Always use sun screen

Clinical Response Factors – Upper face: Check the appropriate box	None	Mild	Moderate	Severe
Skin Laxity: Excess skin or hooding on the eyelid; eyelid droopiness				
Volume: Presence of fat deposits under eyes; infra-orbital puffiness				
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity				
Clinical Response Factors – Lower face and neck: Check the appropriate box	None	Mild	Moderate	Severe
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity				
Volume: Presence of fat deposits in lower face, loss of jaw definition, and/or excessive sub-Q fat				
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity				

PRIVACY POLICY CONSENT HIPAA

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. This notice contains a patient's rights section describing your rights under law. You ascertain that by your signature you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment or healthcare operations.

By signing this for I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice does not have to agree with those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or text to confirm appointments? Yes No

May we phone, email, or text promotions? Yes No

May we leave a message on your answering machine at home or on your cell? May we discuss your medical conditions with any member of your family?

If yes please list the members allowed:

1.) _____ 2.) _____ 3.) _____

Signed by: _____ **Signature:** _____ **Date:** _____