1850 W Lake Houston Pkwy suite 170 | Kingwood TX, 77706
P: (832) 644-8338 F: (832) 644-9560

renovekingwood@gmail.com

Appointment Date:			
Patient's Last Name:		Patient's First Name:	
Birthdate:	Age:	Gender:	Occupation:
Street Address:			
City:	State:	Zip Code:	
Preferred Phone Number:		Email Address:	
Emergency Contact Name:	Emergency Contact Number:	Relationship to Patient:	

Who may we thank for referring you to our office? _____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any charges for services provided.

Signature:_____ Date:_____
(Patient or Guardian)

Thank you for completing the registration form. Please let us know if you have any questions. We promise to provide a comfortable, positive experience at Renove Medical Spa.

Patient Medical History Form

Please print information clearly below. Let us know if you have any questions.

Patient's Last Name:	First Name:	
Birth Date:	Height:	Weight:

Reason(s) for Consultation:

Have you ever been diagnosed with any of the following skin conditions?

	Heat urticaria or hives		Collagen disorders
	Vitiligo		Herpes/cold sores/fever blisters
	Eczema		Skin cancer
	Psoriasis		Sensitivity or allergy to the sun
	Melasma		Abnormal scarring/Keloid

Medical History (Please check any medical conditions that may apply to you)

	Diabetes		Hernia repair
	High blood pressure		Heart disease
	Lung disease or asthma		Autoimmune disorders (like lupus)
	Anemia or blood disorders		Seizures
	Stroke		HIV infection
	Cancer within the last 5 years		Hepatitis
	Pacemaker or defibrillator		Psychiatric disorders
	Renal failure		Metal plates, implants or devices
	Abdominal or colon surgery		History of radiation
	Hormone imbalance/PCOS or Thyroid disorder		

Current Medications (prescription, over the counter, vitamins & supplements):

Have you ever had an allergic reaction to the following? (please check those that apply):

	Latex		Lidocaine		Anesthesia		Topical Anesthetic		Other:

Drug Allergies:	**Reactions:**

Have you taken any of the following medications in the last 6 months?

Doxycycline, Minocycline, Tetracycline	Blood thinners	Accutane or similar pill

Have you had any of the following cosmetic procedures?

O Botox or Dysport	o Laser Resurfacing/Radiofrequency
O Leg Vein Treatment/Sclerotherapy	o Chemical Peels
o Dermal Fillers	o Surgery
o Photofacial/IPL treatments	o Laser Hair Removal
O Microdermabrasion	o Microneedling

Have you had any complications from previous cosmetic surgeries or procedures?

What is your current skin care regimen?_____

Have you used any of the following medications in the last 2 weeks:

	Cortisone		Retin A		Glycolic Acid
	Clindamycin		DesquamX/Zerac		Lactic Acid
	Metrogel		Tazoratene		Salicylic Acid

Have you smoked in the past year?	Yes	No
Do you use any other tobacco products?	Yes	No
Do you drink alcoholic beverages? How often?	Yes	No
Have you used any tanning beds, lamps, or products in the last 6 weeks?	Yes	No
Do you have any permanent makeup or tattoos in an area being treated?	Yes	No

Which of the following best describes your skin type?

	Always burns never tans
	Always burns sometimes tans
	Sometimes burns always tans
	Rarely burns always tans
	Brown, moderately pigmented skin
	Black skin

What is your ethnic background?_____

Women Only:

Are you pregnant or nursing?	Yes	No
Do you have a history of Polycystic ovarian Syndrome?	Yes	No
Do you have an IUD?	Yes	No
Do you leak urine when you cough, sneeze, jump etc.?	Yes	No
Do you have an urgency to use the restroom?	Yes	No
Do you have an underactive sex drive?	Yes	No
Do you have pain during intercourse?	Yes	No
Do you have a problem reaching climax?	Yes	No

Men Only:

Do you suffer from erectile dysfunction?	Yes	No

Is there any other essential information that we need to know? Please use the space below:

Person(s) authorized to discuss my protected medical information and receive copies of my medical history records are:

_____

Authorized Name Relationship Date

I certify that the information provided on this medical history form is correct and complete. Further, I understand that providing incomplete and incorrect information may not only jeopardize my health, but also render ineffective or harmful, any treatment I receive from Dr. Afia Naqvi and her staff.

Signature:_____Date:_____

Thank you for completing your medical history form.

RÉNOVE
MEDICAL SPA

Health Assessment for Women

Name: _____ Date: _____

E-Mail: _____

SYMPTOMS (please check Box)	Never	Mild	Moderate	Severe
1) Fatigue:	☐	☐	☐	☐
2) Mood Changes:	☐	☐	☐	☐
Irritability				
Anxiety / Nervousness				
Depression				
3) Decreased Mental Ability:	☐	☐	☐	☐
Memory Loss				
Confusion				
Loss of Focus				
4) Hot Flashes / Night Sweats	☐	☐	☐	☐
5) Weight Gain:	☐	☐	☐	☐
Bloating				
Excessive Belly Fat				
Inability to Lose Weight				
6) Decreased Sex Drive:	☐	☐	☐	☐
Vaginal Dryness				
7) Sleep Problems:	☐	☐	☐	☐
Can't Stay Asleep				
Can't Fall Asleep				
8) Cold Hands & Feet / Always Cold	☐	☐	☐	☐
9) Hair Loss / Breakage	☐	☐	☐	☐
10) Dry Wrinkled Skin	☐	☐	☐	☐

FAMILY HISTORY (please check Box)	NO	YES
Heart Disease	☐	☐
Diabetes	☐	☐
Osteoporosis	☐	☐
Alzheimer's Disease	☐	☐
Breast Cancer	☐	☐

FINANCIAL RESPONSIBILTY

Thank you for choosing Renove Medical Spa. Our primary mission is to deliver the best and most comprehensive aesthetic care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa, MasterCard, American Express or Discover Card
- Care Credit Healthcare Credit Card

  NO Interest if Paid in Full within 6 Months

  Allows you to pay over time

Please note: Renove Medical Spa requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

No refunds will be given once the treatment has been completed.

When booking an extensive treatment in advance we require 50% of the total cost down to hold as a guarantee for your appointment as we will be ordering or holding product specifically for you and your treatment.

Renove Medical Spa charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

CANCELLATION POLICY

Our goal is to provide quality care to all our clients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our providers, but our other clients as well. Please be aware of our policy regarding missed appointments.

Appointment Cancellation

our other clients. In order to be respectful of your fellow clients, please call our office within 24hrs of the appointment to cancel or reschedule. Failure to do so will result in being **charged $25.00 for the late notice.**

Appointments are in high demand, and your advanced notice will allow another client access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call us at 832-644-8338 between the hours of 9am–5pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible. If it is after business hours, we can be reached via email at renovekingwood@gmail.com or by text at 832-583-2304

Same Day Cancellations/No-Shows

A same day cancellation is when the appointment is cancelled the day of the appointment. A no-show is when a client misses an appointment without cancelling. In either case, we will charge the client a $25 missed appointment fee.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Photograph / Media Consent Form

I,_____

(Print Name)

Please circle which option you voluntarily consent to.

I. I consent to the use of photographs and/or video footage for use on the Renove Medical Spa's website, social media accounts and/or any future advertising mediums and am okay with having my identity shown.

Il. I consent to the use of photographs and/or video footage for use on Renove Medical Spa's website, social media accounts and/or any future advertising mediums but wish to have my identity concealed by use of angles and/or a white bar across my eyes.

Ill. I do not wish to have photographs or video of myself of the Renove Medical Spa's website, social media and/or any future advertising mediums.

IV. I consent to Renove Medical Spa sharing my cell phone number and information with CMA in order for them to text me approximately once every 3 months to gain information about my results in an attempt to provide the best treatments and results moving forward.

_____

Signature

_____

Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time

FOR OFFICE USE ONLY

Name:_____ DOB:_____ DOC:_____

PHYSICIANS NOTES

Concerns: _____

Face: _____

_____

_____

_____

_____

Body: _____

_____

_____

_____

_____

PHYSICIAN'S RECOMMENDED TREATMENT(S):

_____

_____

_____

_____

_____

Pricing:

_____

:

_____

FOR OFFICE USE ONLY

Name:_____ DOB:_____ DOC:_____

OFFICE NOTES: