Viora Intake & Consent

5191 S. Yosemite St., Suite B, Greenwood Village, CO 80111

Please complete all areas as completely and accurately as possible. ALL AREAS ARE VALID. All information is private.

Patient Contact Information

Name: ____ Date: ___________

Address:_____________________________City:______________ State:____ Zip:__________

DOB ___/___/_____ Age: ____ □ Male □ Female If minor, name of parent: _________________

Cell #(______)________________ Home Phone: (______)___________ Work#(_____)___________

E-mail address: ______________________ Employer: ___________ Occupation:___________

Married or have a life partner? Yes No Significant other's name: ______________________

Emergency Contact: _______________ Relationship: __________ Phone:(_______)__________

2nd Contact: ____________________ Relationship: __________ Phone:(_______)__________

How did you hear of us? Referral: _______________ Doctor: ______________________

Internet: ___________________ Advertisement: _______________

Other: __________________

Current Concern:____

Desired Goal/s:____

Treatment Expectations:____

List modalities you have tried in the past:____

____

Were you happy with the results? ____

What did this modality not accomplish for you?__________________________________

When was the last time that you had this done?_________________________________

How long has this been a concern for you?

- ☐ Days
- ☐ Weeks
- ☐ Months
- ☐ Years, How Many?__________

Does this concern affect your self-esteem, work, life, etc. ?______________________________

Please list all current medical conditions:

____
____
____

Please list any current medications you are taking, including hormones:

____
____
____
____
____

Do you have a regular skin care regimen? Please describe, if so:

____
____
____

How much water do you drink daily?____

How much time do you spend exposed to the sun?____

Do you wear sunscreen daily? If so, what is the SPF?____

Do you follow a regular exercise routine?____

How committed are you to reaching your desired goal?

- ☐ Very committed
- ☐ Somewhat committed
- ☐ I've been thinking about it

Please check off any that apply to you:

- ☐ Currently pregnant or trying to conceive
- ☐ Currently breastfeeding or any breastfeeding in the past 3 months
- ☐ History of keloids or unusual scarring
- ☐ History of Herpes Simplex recurring in area to be treated
- ☐ Use of Accutane in past 6 months
- ☐ Use of Rogaine for hair loss
- ☐ Current use of Retin-A/Renova/Differin, glycolic acid products, or hydroquinone on treatment area
- ☐ Recent waxing, plucking, or electrolysis performed on treatment area in past 6 weeks
- ☐ Frequent or recent traveling to a sunny area
- ☐ Tattoos in treatment area
- ☐ Pacemaker or other Implanted Electronic or Metallic Device
- ☐ History or current diagnosis of cancer
- ☐ Fragile and/or dry skin
- ☐ Hormonal disorders

- ☐ Anticoagulant use (i.e. Warfarin, Heparin)
- ☐ Undiagnosed lesions
- ☐ Diseases that are stimulated by light
- ☐ Diabetes (is it under control?) or other Endocrine Disorder
- ☐ Hepatitis or Liver Disease
- ☐ Uncontrolled Thyroid Disorder
- ☐ Excessive Bleeding or Bruising
- ☐ Aesthetic or Medical Surgery in past 3 months
- ☐ Vitiligo (Hypopigmentation)
- ☐ Epilepsy
- ☐ Inflammation at treatment area
- ☐ Permanent makeup on treatment area
- ☐ Moles on treatment area

I hereby certify that all the above information is true to the best of my knowledge.

Patient/Parent/Guardian Printed Name ____

Patient/Parent/Guardian Signature ______________________________ Date ________________

Integrative Health, Inc
5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
Phone: 303-577-9977
www.IntegrativeHealthInc.com

VIORA CONSENT

I duly authorize, Integrative Health, Inc. and other specially trained associate technicians of this facility, to perform treatments using the Viora Laser and handpiece for V-FORM, V-IPL, and/or V-S.

I am hereby undertaking the responsibility of the treatment outcome.

Possible risks and side effects of the treatment which may include local pain, erythema, edema, itching and sensitivity to touch, urticaria, purpura or ecchymosis, hematoma, allergic contact dermatitis to glycerin oil or acoustic contact gel, bruise, blister, burn, hyper- and hypo pigmentation. All side effects are transient and mild, however in the event of adverse side effects the treating personnel must be informed and a physician consultation may be necessary.

My questions regarding this procedure have been answered to my satisfaction. I accept all risks of treatment and agree to follow aftercare as directed by this facility.

Patient/Parent/Guardian Printed Name ____

Patient/Parent/Guardian Signature ______________________________ **Date** ________________

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Greenwood Village, CO 80111
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_________ (initial) I, hereby understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient, I realize I am not being treated by Integrative Health Inc., but the specific provider's business seen by. Integrative Health is not your health care provider and cannot be held responsible to any harm or damages to your person. I, hereby release Integrative Health Inc. from any damages that could occur to my person.

Consent For Care

_________ (initial) I, herby authorize and request the provider(s) in which I scheduled with at 5191 S Yosemite St, Ste B, to perform such examinations and therapeutic treatments as in the judgement of the provider(s). I understand I am not forced to accept medical treatment.

Authorization To Release Information

_________ (initial) I AUTHORIZE the provider(s) seen at 5191 S Yosemite Street, Ste B, to release any information required to process this claim to any insurance company or attorney involved in my case. I also authorize any insurance company or medical provider to release my medical records to the provider(s) at 5191 S Yosemite St, Ste B. The information is to be used for the purpose of preceding my claim for benefits due.

_________ (initial) I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may request a copy of my records at any time and a fee may apply.

Payment Agreement

_________ (initial) I assume full responsibility for and agree to pay all costs, charges and expenses for goods and services furnished by provider(s) seen at 5191 S Yosemite St, Ste B, at time of service.

_________ (initial) I hereby authorize my insurance benefits to be paid directly to the provider(s) seen at 5191 S Yosemite St, Ste B. I must pay charges and services not covered by any insurer third-party and/or paid to the providers(s) seen at 5191 S Yosemite St, Ste B, for any reason within a time period deemed reasonable by the provider(s). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

Cancellation Notice

_________ (initial) Kindly give 24 HOURS NOTICE for cancellations. Late cancellations are subject to 50% CANCELLATION FEE, no shows or cancellation with less than 2 hours before scheduled appointment are subject to a 100% CANCELLATION FEE. Cancellation fee is based on the cash rate of service. Call-backs or email reminders are a courtesy and I understand that I am responsible for my appointment and providing 24 hour notice for cancellations or reschedules.

____

Your Printed Name

____ ____________

Signature Date

Integrative Health Inc
5191 S Yosemite St, Suite B, Greenwood Village, CO 80111
Phone: 303-577-9977 Fax: 303-694-4341
www.IntegrativeHealthInc.com

Consent for Purpose of Treatment and Healthcare Operations

In this document, "I" and "my" refer to the patient/client

I consent to the use or disclosure of my protected health information by the provider(s) seen at Integrative Health Inc, 5191 S Yosemite St, Ste B., for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or my treatment may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, the provider(s) seen are not required to agree to the restrictions that I may request. However, if the provider(s) agrees to a restriction that I request, the restriction is binding on the provider(s). I have the right to revoke this consent, in writing at any time, except to the extent that the provider(s) has taken action in the reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may review the Notice of Privacy Practices online on the link provided below and understand that I have the right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Health, as well as my rights and duties of the provider(s) seen at 5191 S Yosemite St, Ste B, with respect to my protected health information.

The Notice of Privacy Practices is available online at: https://www.hhs.gov/hipaa/for-individuals/index.html

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Your Printed Name

____ _____________

Signature Date