Radiant You
AESTHETICS

Client Information

Client Name

First Name Last Name

Today's Visit

What is the reason for your visit today? ______________________________

Patient Demographics

Address City State ZIP

Tel No. Gender ☐ M ☐ F DOB: _____/____/______

Email Address

Race ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Mixed Race ☐ White ☐ Other ☐ Decline

Ethnicity ☐ Hispanic ☐ Not Hispanic ☐ Decline

Emergency Contact Information

Contact Name Telephone No. Relationship to Client

Patient Employment Information

Employer Employer Telephone No.

Parent / Responsible Party (If someone other than client)

First Name Last Name

Address City State ZIP

Tel No. Gender ☐ M ☐ F DOB: _____/____/______

Email Address

Pharmacy Information

Address City State ZIP

Telephone No.

Radiant You AESTHETICS

Client Consent

Patient Consent for Treatment

1. I voluntarily consent to any and all aesthetics treatment and procedures provided by Radiant You and its staff members and associated professionals. I understand that no guarantee has been or can be made as to the results of the treatments.

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2. I authorize payment of aesthetics procedures and treatments by Radiant You Aesthetics.

Patient Photography Release Form

3. I have been advised that photographs will be taken of me, or parts of my body, before and after aesthetic procedures. The photographs will be taken by one of Radiant You staff members. These photographs will ONLY be used to view progress results.

I have received a copy of Financial Policy Notice and the Release of Information.	Initial	

Client Signature or Authorized Representative

Date

67 Holly Hill Lane, Suite 101, • Greenwich, CT 06830 • Tel: (203).970. 4020 • Email: info@radiantyouaesthetics.com
www.radiantyouaesthetics.com

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Client Medical History

Date: ______________________

Name: ______________________ DOB: ______________________

Allergies

If you have no known allergies, please check the box on right. ☐ None known

1. Medication ______________________ Reaction ______________________
2. Medication Reaction

Do you have now or have you ever had diseases or conditions of:

☐ Hypertension	☐ Psoriasis	☐ Keloids	☐ Radiation
☐ Diabetes	☐ Lupus	☐ Hepatitis	☐ Preskin Cancer
☐ Caner	☐ Acne	☐ AIDS/HIV	
☐ Skin Cancer	☐ Basel Cell	☐ Squamous Cell	☐ Melanoma
☐ History of Cold Soar?			

How did you hear about our services?

☐ Website	☐ Facebook / Twitter	☐ Doctor Referral	☐ Staff Member	☐ Web Search
☐ Hospital	☐ Advertisement	☐ Referral	☐ Other	

Skincare Questionnaire

1. Have you had laser treatment? ☐ Yes ☐ No
2. Do you sun tan? ☐ Yes ☐ No
3. Do you use tanning beds? ☐ Yes ☐ No
4. Do you spray tan? ☐ Yes ☐ No
5. Do you use sunscreen daily? ☐ Yes ☐ No
6. Do you have Rosacea? ☐ Yes ☐ No
7. Characterize your skin? ☐ Sensitive ☐ Dry ☐ Oily ☐ Rough
8. Describe current skin care regimen?

Cosmetic Questionnaire

Please Check Off Any Cosmetic Concern And Procedures you are interested in discussing:

☐ Botox	☐ Skin Tightening	☐ Chemical Peels
☐ Fillers	☐ Broken Capillaries	☐ Facials
☐ Anti-Aging Products	☐ Laser Hair Removal	☐ DermaPlanning
☐ Wrinkles	☐ LED Light Therapy	☐ Leg Veins
☐ Fat Loss	☐ Brown Spots	☐ Microdermabrasion

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Financial Policy & Disclosure

The Financial Policy and Disclosure is to help us provide the most efficient and reasonable aesthetics care. Therefore, it is necessary for us to have a Financial Policy and Disclosure stating our requirements for payment for services rendered.

I, ______________________________________, understand that it is my responsibility to notify Radiant You Aesthetics 24 hours prior to scheduled appointment if I am unable to keep appointment.

I understand and agree I will be charged 50% of the service appointment fee for failure to cancel 24 hours prior to scheduled appointment.

By signing below, I agree to charge my credit card for all services rendered.

Please provide credit card information below:

CREDIT CARD NUMBER:	
EXP DATE:	
SECURITY CODE:	

____ ____________________

Client Signature or Authorized Representative Date

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AESTHETICS

Authorization for Release of Information

Client Name	DOB

Radiant You Aesthetics is authorized to release Protected Health Information (PHI) about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the client's instructions.

Person to Receive Information. Check each person that you approve to receive information.	**Description of Information to be released.** Check each that can be given to person on the left in the same section.
☐ Voicemail	☐ Results ☐ Other
☐ Spouse (Provide Name & Tel No.)	☐ Financial ☐ Cosmetic
☐ Parent	☐ Financial ☐ Cosmetic
☐ Email communication	☐ Financial ☐ Cosmetic

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the PHI to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the client.

Client Signature or Authorized Representative

Date