484 S Miller Road, Suite 201, Fairlawn, Ohio 44333 PH 330-801-9069 website: FairlawnAestheticMD.com

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____Today's Date_____

Date of Birth _____/_____ /_____ Age_____Occupation_____

Home Address _____City _____State ____Zip Code_____

Cell Phone (____) _____Email Address _____

Permission to Call and/or Text regarding scheduling, procedures, aftercare and follow up. D Yes D No

Emergency Contact Name and Phone_____

How were you referred to us? Family/Friend_____(please specify)

Facebook Google Website Drive by Radio Television Instagram

Newspaper Other_____(please specify)

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans
II Always burns, sometimes tans
III Sometimes burns, always tans
IV Rarely burns, always tans
V Brown, moderately pigmented skin
VI Black skin

Do you regularly use tanning salons or sun bathe?_____ How often? _____

MEDICAL HISTORY

Are you currently under the care of a physician? D Yes D No If yes, for what:_____

Are you currently under the care of a dermatologist? D Yes D No If yes, for what:_____

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? D Yes D No

Do you have any of the following medical conditions? (Please check all that apply)

D Cancer D Diabetes D High blood pressure D Herpes D Arthritis D Frequent cold sores D HIV/AIDS

D Keloid scarring D Skin disease/Skin lesions D Seizure disorder D Hepatitis D Hormone imbalance

D Thyroid imbalance D Blood clotting abnormalities D Any active infection D Melasma

D Do you have any other health problems or medical conditions? Please list: _____

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Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) D Food D Latex D Aspirin D Lidocaine D Hydrocortisone D Hydroquinone or skin bleaching agents Others:_____

MEDICATIONS

What oral medications are you presently taking? D Birth control pills D Hormones D Blood thinners

D Others (Please list): _____

Are you on any mood altering or anti-depression medication?_____

Have you ever used Accutane? D Yes D No. If yes, when did you last use it?_____

What topical medications or creams are you currently using? D Retin-A® D Others (Please list):

What herbal supplements do you use regularly?_____

HISTORY

Have you ever had laser hair removal? D Yes D No

Have you used any of the following hair removal methods in the past six weeks?

D Shaving D Waxing D Electrolysis D Plucking D Tweezing D Stringing D Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? D Yes D No

Have you recently used any self-tanning lotions or treatments? D Yes D No

Do you form thick or raised scars from cuts or burns? D Yes D No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? D Yes D No If yes, please describe: _____

For our female clients:

Are you pregnant or trying to become pregnant? D Yes D No Are you breastfeeding? D Yes D No Are you using contraception? D Yes D No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____Date: _____

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CONSENT TO PHOTOGRAPH

I give my consent to photographs for medical records only. If used for education and advertising, I will not be identified by name and will give consent on a separate form.

Signature of participant _____ Date_____

Signature of Witness _____ Date_____

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Cancellation and Refund Policy – Injectable Treatments

Cancellations:
We require a credit card on file to hold your appointment. There will be no charge to the credit card as long as you attend the appointment or cancel/reschedule within 24 hours. Otherwise we reserve the right to charge your credit card for the amount of $50.00.

Refund Policy:
Treatments purchased are non-refundable, non-transferable and non-exchangeable.

Cancellation and Refund policy – Aesthetic Services

Cancellations:
We ask that you notify us at least 24 hours in advance if you are unable to keep your appointment.
Refund Policy:
Treatments purchased are non-refundable, non-transferable and non-exchangeable.
No Show Policy:
Please be courteous and cancel if you change your mind. There will be a $45 no show fee added to your next service.

_____
Patient Name (Printed)

_____
Patient Signature

_____
Date

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Ohio law, and not by a lawsuit or resort to court process except as Ohio law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a Ohio superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Ohio law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: Signature on File
Physician's or Duly Authorized Representative Signature (Date)

By Matthew McDaniel, MD
Print or Stamp Name of Physician, Medical Group or Association Name

By:
Signature of Translator (if applicable) (Date)

Print Name of Translator

By:
Patient's Signature (Date)

Print Patient's Name

By:
Patient's Representative's Signature (if applicable)(Date)

Print Name and Relationship to Patient