THE CENTRE, P.C.

Patient Information Form

Patient

Last Name: ____________ First Name: ____________ Mid ____ DOB: ________ Age: ______

Address: ____________ City: ____________ State: ________ Zip: ______

Home Phone: ____________ Cell Phone: ____________ Preferred Carrier: ____________

Gender ☐ F ☐ M Social Security Number ____________ Ethnicity: Hispanic or Latino ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Unknown

Race: ☐ Black ☐ American Indian/Native ☐ Hispanic/ Latino ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Other

Employer

Employer Name: ____________ Address: ____________ Phone: ________

List your Occupation (including basic duties): ____________

Is this a work-related injury? ☐ Yes ☐ No Supervisor's Name: ____________

How did the injury occur? ____________

Spouse/Guardian/Emergency Contact

Name: ____________ Relationship: ____________ Phone: ________

Address: ____________ City: ____________ State: ________ Zip: ______

Do you give consent to the above contact to discuss your medical information in your absence or should you be unable to speak? ☐ **Yes** ☐ **No**

Insurance

	Primary	**Secondary**
Ins. Co Name		
Ins. Co Address		
Ins. Co, City/State/Zip		
Policy Holders' Name		
Group Number		
Policy Number		
Employer		

Visit Reason

Reason for today's visit? ____________

How did you hear about us? (ex. TV, radio, social media, etc. – list) ____________

Who may we thank for referring you to us? ____________

Have you had prior surgery on this area? ☐ Yes ☐ No If so when and where? ____________

Were you referred by another physician? ☐ Yes ☐ No Physicians Name ____________

Primary Care Physician ____________ Phone # ____________

FAMILY HEALTH BACKGROUND

Do any of your blood relatives have the following?

	Yes	No	Relationship to Patient	Age if Living	Age of Death & Cause of Death
Allergies	□	□			
Birth Defects	□	□			
Blood Disorder	□	□			
Breast Disease	□	□			
Cancer-List ______________	□	□			
Diabetes	□	□			
Genetic Defects	□	□			
Heart Disease	□	□			
High Blood Pressure	□	□			
Lung Disease	□	□			
Other	□	□			

Women Only: Are you Pregnant? □ Yes □ No □ Unsure Week# ______________

Consumption of the following:		**Amount/#**	**Circle one:**
Alcohol	□ Yes □ No	____________	Daily or Weekly
Aspirin	□ Yes □ No	____________	Daily or Weekly
Ibuprofen (Advil, Motrin, Nuprin)	□ Yes □ No	____________	Daily or Weekly
Tylenol	□ Yes □ No	____________	Daily or Weekly
Caffeine (pop, coffee)	□ Yes □ No	____________	Daily or Weekly

Tobacco Products:		Former Smoker		Never Smoked		Current Smoker		Social Smoker		
Check what applies:		Cigars		E-Cigarettes		Nicotine Gum		Chewing Tobacco		Patches
		Vaping								

Do you presently have or have you ever experienced the following?

Yes	No		Yes	No		Yes	No		Yes	No	
□	□	Acne	□	□	Chicken Pox	□	□	Herpes	□	□	Scarlet Fever
□	□	AIDS/HIV	□	□	Cold Sores	□	□	High Blood Pressure	□	□	Seizure/Epilepsy
□	□	Alcohol Abuse	□	□	Colitis	□	□	Hospitalized	□	□	Shingles
□	□	Anemia	□	□	Congenital Heart ect	□	□	Kidney Problems	□	□	Sickle Cell Disease
□	□	Anxiety	□	□	Coronary Artery ease	□	□	Liver Problems	□	□	Sinus Problems
□	□	Arthritis	□	□	Diabetes	□	□	Low Blood Pressure	□	□	Stroke
□	□	Artificial Bones/Joints	□	□	Difficulty Breathing	□	□	Mental Illness/Depression	□	□	Sun Exposure
□	□	Artificial Valves	□	□	Drug Abuse	□	□	Mitral Valve Prolapse	□	□	Tanning Products
□	□	Asthma	□	□	Eczema/Rosacea/Psoriasis	□	□	MRSA	□	□	Thyroid Problems
□	□	Auto Immune Disease	□	□	Emphysema	□	□	Neuromuscular Disorder	□	□	Tonsillitis
□	□	Bell's Palsy	□	□	Fainting Spells	□	□	Pacemaker	□	□	Tuberculosis
□	□	Beta Thalassemia's	□	□	Frequent Headaches	□	□	Persistent Cough	□	□	Undiagnosed Cough
□	□	Cancer – List	□	□	Glaucoma	□	□	Radiation Treatment	□	□	Ulcers
□	□	Cardiac Stents	□	□	Hay Fever	□	□	Reproductive Disorder	□	□	Venereal Disease (VD)
□	□	Chemotherapy	□	□	Hepatitis	□	□	Rheumatic Fever			

Blood Disorder: □ None ***Other not listed*:** ______________________

Circle if any applies: Abnormal bleeding Clots Cryoglobulinemia Hemophilia

Previous Surgeries: (type, when, where) □ None ______________________

____

Are you allergic to any of the following?

□ Yes	□ No	Aspirin	□ Yes	□ No	Codeine	□ Yes	□ No	Phenol	□ Yes	Other______________
□ Yes	□ No	Barbiturates	□ Yes	□ No	Jewelry	□ Yes	□ No	Sedatives	□ Yes	Other______________
□ Yes	□ No	Eggs	□ Yes	□ No	Latex	□ Yes	□ No	Sulfa Drugs	□ Yes	Other______________
□ Yes	□ No	Erythromycin	□ Yes	□ No	Penicillin	□ Yes	□ No	Tetracycline	□ Yes	Other______________

Medications (include prescription and non-prescription medications that you are currently taking) – I take no medications □

Name	Dosage	How Often	Name	Dosage	How Often

REVIEW OF SYSTEMS (within the last month have you had…)

CONSTITUTIONAL		**EYES, EARS, NOSE & THROAT**		**EXTREMITIES**	
□ Yes □ No	Weight loss; If so, how much? _______lbs.	□ Yes □ No	Sinus infection/pain	□ Yes □ No	Redness of a limb
□ Yes □ No	Decrease in energy	□ Yes □ No	Ear pain	□ Yes □ No	Swelling of a limb
□ Yes □ No	Decrease in appetite	□ Yes □ No	Change in hearing	□ Yes □ No	Discoloration of a limb
□ Yes □ No	Night sweats	□ Yes □ No	Eye pain		
□ Yes □ No	Fever; If so, how high? _____________	□ Yes □ No	Change in vision	**SKIN/INTEGUMENTARY**	
HEMATOLOGIC		□ Yes □ No	Nasal discharge	□ Yes □ No	Abnormal growths
□ Yes □ No	Cold intolerance	□ Yes □ No	Throat pain	□ Yes □ No	Lesions
□ Yes □ No	Easy bruising	□ Yes □ No	Sleep Apnea	□ Yes □ No	Jaundice
□ Yes □ No	Nosebleeds, rectal bleeding or bleeding at other sites	**NEUROLOGICAL**		□ Yes □ No	Rashes
		□ Yes □ No	Headaches	□ Yes □ No	Ulcers
GASTROINTESTINAL		□ Yes □ No	Troublesome or frequent headaches	**MUSCULOSKELETAL**	
□ Yes □ No	Difficulty swallowing food	□ Yes □ No	Recent change in vision	□ Yes □ No	Arthritis
□ Yes □ No	Pain with swallowing food	□ Yes □ No	Recent change in hearing	□ Yes □ No	Back pain
□ Yes □ No	Indigestion	□ Yes □ No	Change in ability to feel things	□ Yes □ No	New back pain
□ Yes □ No	Nausea	□ Yes □ No	Painful sensations	□ Yes □ No	Bone pain
□ Yes □ No	Vomiting	□ Yes □ No	Decrease in muscle strength	□ Yes □ No	Muscle soreness
□ Yes □ No	Diarrhea	□ Yes □ No	Decrease in ability to ambulate	□ Yes □ No	Recent trauma or fractures
□ Yes □ No	Abdominal bloating	□ Yes □ No	Experience memory loss		
□ Yes □ No	Black stools	**RESPIRATORY**		**PSYCHIATRIC**	
□ Yes □ No	Blood from the rectum	□ Yes □ No	Blood in sputum	□ Yes □ No	Change in mood
CARDIAC		□ Yes □ No	Coughing or changes in cough	□ Yes □ No	Experience anxiety
□ Yes □ No	Chest pain	□ Yes □ No	Shortness of breath	□ Yes □ No	Change in behavior with family
□ Yes □ No	Palpitations	□ Yes □ No	Mucous production with cough	□ Yes □ No	Change in ability to think
□ Yes □ No	Shortness of Breath	**GENITOURINARY**		□ Yes □ No	Losing track of where one is, what time it is or who one is with
□ Yes □ No	Fatigue	□ Yes □ No	Burning with urination		
□ Yes □ No	Decrease in ability to exert oneself	□ Yes □ No	Blood in urine		
□ Yes □ No	Episodes of shortness of breath at night	□ Yes □ No	Increase in need to urinate	□ Yes □ No	Increase in need to urinate at night

I affirm under the penalties of perjury that the above statements are true.

____ _____________________________

Patient Signature **Date**

____ _____________________________

Parent/Guardian **Date**

*****If updating and verifying previous information, please initial that all information is correct.**

CONSENT FOR PHOTOS OR VIDEO RECORDINGS, COMMUNICATION BY EMAIL/TEXT MESSAGE, TRANSMISSION OF PROTECTED HEALTH INFORMATION (PHI), OR TELEHEALTH CONSULTATION

PHOTOGRAPHIC RELEASE AND CONSENT

I, agree that The Centre, P.C. ("The Practice") or designated representatives of The Practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes and such other purposes ***AS I HAVE INITIALED BELOW*** and stated photographs shall remain the property of The Centre, P.C.

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as **indicated by my initials below**. As a result of this use, I understand that these photographs, videotapes, or case information may appear in other related, updated, or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand some photographs may, by their representation make me identifiable in appearance to others. I authorize The Centre, P.C. to use my photographs, videotapes, and case information in the following educational and scientific settings which I have initialed:

______ The Practice's or my surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office and on-line.

______ Newspaper and magazine articles in which The Practice or my surgeon participates.

______ Television programs in which my surgeon or The Practice participates.

______ My surgeon's professional web site or web page.

______ Lectures and multimedia presentations given by my surgeon or provider for the general public.

______ Social media including Facebook, Instagram, Twitter, Pinterest, and any future social media streams.

NO USE OF MY PHOTOGRAPHS IS AUTHORIZED AS PER MY SIGNATURE BELOW.

Patient Signature ______________________________ Date ______________________________

RELEASE OF PHOTOGRAPHS AND/OR VIDEO RECORDINGS (FOR ADVERTISING PURPOSES)

Voluntary participation

I understand I am voluntarily agreeing to allow The Centre, P.C. to use my photographs and/or video recordings ("Content") in product/service-related advertising, online media, 3rd party vendor advertising and promotion. I waive any right of inspection or approval of the photographs/video recordings prior to use as stated above. I agree The Centre, P.C. is under no obligation to use the "Content," as defined below.

Grant of Rights to Content

I agree that The Centre, P.C. may take photographs and/or video recordings of me in connection with product/service-related advertising, online media, 3rd party vendor advertising and promotion. The Centre, PC shall be the exclusive owner of the photographs and/or video recordings (collectively "Content"), whether included in related advertising and promotion, or not, including all associated rights and intellectual property rights, throughout the universe in perpetuity. I further agree that The Centre, P.C. has the unlimited and unrestricted right and permission to copyright, use, re-use, publish, re-publish, distribute, publicly display, publicly perform, make derivative works and license others to use, in any manner, the photographic portraits, pictures and/or video recordings of me in which I may be included, in whole or in part, or reproduction thereof in color or otherwise, made through any and all media now or hereafter known, for illustration, promotion, advertising, commerce, or any other purpose whatsoever throughout the universe in perpetuity. I further agree that The Centre, P.C. may transfer any and all of their rights hereunder as it sees fit.

I expressly waive any and all moral rights I may have in connection with Content. I represent that any statements made by me are true, to the best of my knowledge, and that neither they nor use of the Content will violate or infringe upon the rights of any third party. I acknowledge that The Centre, P.C. will rely on this permission, at substantial cost to them, and hereby agree not to assert any claim of any nature whatsoever against anyone relating to the exercise of the permission granted hereunder.

Release of Claims

Further, I do for myself, my heirs, legal representatives and assigns hereby release, waive and discharge The Centre, P.C. and its officers, directors, employees, agents, affiliates and other representatives ("Released Parties") of all liabilities, claims, actions, damages, costs, or expenses (including attorneys' fees) which I may have against them of any nature arising out of or resulting from my appearance in the content or related advertising and promotions for any claims for defamation, misappropriation of the right of publicity and/or invasion of privacy or other legal theories related to this Release.

Indemnification
I agree to indemnify and hold harmless The Centre, P.C. and its respective officers, directors, employees, agents, affiliates, assigns and other representatives from and against any and all claims, damages, liabilities, costs, and expenses (including attorneys' fees) arising from a breach by me of any of the representations or warranties provided herein, or due to my negligence or willful misconduct.

Please check by your initials your appropriate response below:

	I am over 18 years of age. I have read and fully understand and **DO voluntarily sign this irrevocable Release and Waiver** and further agree that no oral representation or other inducements apart from this written agreement have been made. I understand that this is the entire agreement between The Centre, P.C. and me.
	I am over 18 years of age. I have read and fully understand and **DO NOT agree to voluntarily sign this irrevocable Release and Waiver** and further agree that no oral representation or other inducements apart from this written agreement have been made.

COMMUNICATION BY EMAIL & TEXT MESSAGE

It may become useful during the course of treatment to communicate by email, text message (e.g., "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with The Centre, P.C./L.L.C. there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow The Centre, P.C./L.L.C. to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing offers

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Please check by your initials your appropriate response below:

	I am over 18 years of age. I have read and fully understand and **DO voluntarily consent** for Transmission of Protected Health Information by Non-Secure Means.
	I am over 18 years of age. I have read and fully understand and **DO NOT consent** for Transmission of Protected Health Information by Non-Secure Means.

INFORMED CONSENT FOR TELEHEALTH CONSULTATION

I understand Telehealth includes the evaluation of my medical history, assessment, consultation, and treatment plan. I understand I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand the information disclosed by me during the course of my sessions is confidential. I also understand the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. The Centre, PC utilizes secure, HIPPA compliant audio/video transmission software to deliver telehealth.
4. I understand if my provider believes I would be better served by another form of intervention (e.g., face-to-face consultation), I will be scheduled appropriately.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology.
6. I understand I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

I have read and understand the information provided above regarding telemedicine and all of my questions have been answered to my satisfaction.

Please check by your initials your appropriate response below:

	I hereby voluntarily give my informed consent for the use of telemedicine in my medical care. I hereby authorize said provider to use telemedicine in the course of my diagnosis and treatment.
	I hereby DO NOT give my informed consent for the use of telemedicine in my medical care. I hereby **DO NOT** authorize said provider to use telemedicine in the course of my diagnosis and treatment.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I hereby acknowledge I have been shown The Centre, P.C. Notice of Privacy Practices for Protected Health Information. I acknowledge I have read and fully understand the Notice. I have been provided the opportunity to ask questions about the Notice and my questions have been answered to my satisfaction.

Please check by your initials your appropriate response below:

	I AM REQUESTING to receive a copy of The Centre, P.C. Notice of Privacy Practices for Protected Health Information.
	I choose NOT to receive a copy of The Centre, P.C. Notice of Privacy Practices for Protected Health Information.

AUTHORIZED TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment directly to the undersigned physician or licensed provider of any surgical and/or medical benefits, if any, otherwise payable to me for his/her services. Ultimately, I understand that I am financially responsible for the services rendered.

Patient Signature ______________________________ Date ______________________________

Witness Signature ______________________________ Date ______________________________

CENTRE YOURSELF MEDICAL SPA PROCEDURES AND FINANCIAL POLICES

We have created the following policies to provide our patients with the best possible services and experiences. These policies are necessary to avoid expenses and valuable time for both our patient and our professionals. As we strive to provide the absolute best result for all our patients, we ask that you please read over and sign the Medical Spa Policies and understand we must enforce them to achieve our stated goals.

APPOINTMENTS

Please contact us at 574-968-3510 to schedule an appointment. Please schedule your appointments in advance to ensure your preferred time is available.

All client consultation appointments will require a $50 reservation fee that will be applied to the selected treatment. However, if you do not schedule any treatments the $50 fee will NOT be refunded, but rather used as the consultation fee. If you are a **"NO SHOW"** for your consultation appointment or cancel less than 48 hours in advance, you will forfeit the $50 fee.

PRIOR TO YOUR SCHEDULED APPOINTMENT AFTER CONSULTATION

Please review your pre-care and post-care instructions provided during your consultation. These instructions are specific to the service you are receiving and must be followed to receive the best possible results. Failure to follow and comply with signed pre-care and post-care instructions may result in the rescheduling of your service.

For example, all laser hair removal clients should arrive having shaved ***one day*** before the appointment. By doing this there is a little hair that can be targeted by the laser beam for an effective treatment. You should never "pluck or wax" prior to receiving a laser hair removal service.

For many of our services we cannot treat patients that have sun/UV exposure. That is why it is imperative that you understand your Pre and Post care instructions.

ARRIVAL TIME FOR MY APPOINTMENT

Please arrive 15 minutes prior to your scheduled appointment time to prepare for your treatment or service. Because we are a Medical Spa, you may need to update or complete required medical documents prior to your treatment or service.

Please note - If scheduled for *Dermal Filler, Neurotoxin, Laser treatment or vaginal rejuvenation,* **it is imperative you arrive 15 minutes prior to the scheduled time** to prepare for these treatments.

APPOINTMENTS - LATE ARRIVALS/RESCHEDULING/CANCELLING APPOINTMENT/"NO SHOW"

To assist patients and clients in keeping their scheduled appointments, The Centre, P.C. will utilize various reminder systems which include, but are not limited to telephone calls, text messages, appointment cards, and emails. It is the patient/client's responsibility to provide The Centre, P.C. with accurate information regarding their contact information. The Centre, P.C. will utilize all forms of available patient/client contact information to confirm the scheduled appointment.

Late Arrival/Rescheduling

Due to the nature of these medical services, each appointment is scheduled for the proper amount of time required to complete the treatment or service. All appointments must begin and end on time to provide each client with the optimal treatment. Should you arrive more than ten (10) minutes late, your appointment will likely need to be rescheduled. For those traveling some distance, it is always recommended to contact our office immediately in the event you foresee arriving late.

We can't accept late arrivals for Neurotoxin appointments due to the allotted 15-minute appointment time. In some instances, we may have a later appointment open that day and may be able to move your appointment time accordingly.

If no appointments are available, your appointment will be rescheduled to the soonest appointment time available or placed on a waiting list. We apologize in advance for any inconvenience this may cause; however, *the responsibility rests*

with you to be on time for your scheduled appointment. We will do our best to accommodate your availability when rescheduling your appointment. If you arrive late to your scheduled appointment to the extend it must be cancelled and rescheduled (even a same day rescheduling) a "No Show" fee will be accessed as outlined below.

Appointment Cancelling/"No Show" – Associated Fee

If you are unable to keep your scheduled appointment for any reason, ***you must notify our office within 48 hours of your scheduled appointment time*** (after hours you will speak with our answering service). If you do not notify our office within the 48 hours, you will be considered a **"NO SHOW".**

A cancellation fee will be charged to patients that do not cancel their appointment within 48 hours, "No Show" to their appointment, or arrive late to their scheduled appointment to the extend it must be cancelled and rescheduled.

The cancellation fee will be as follows and is based on the Provider's lost time for the cancelled appointment:

- Appointments scheduled for 1 hour (60 minutes) or less: $50 fee
- Appointments scheduled for more than 1 hour (60 minutes) will be charged:
  - $50 per hour, rounding up to the nearest hour.
  - For example, an appointment of 1 hour & 15 minutes will be rounded up to 2 hours and charged a $50 x 2 = $100 fee.

We realize life happens. Certain circumstances may create the need to cancel an appointment with less than 48 hours advance notice (i.e., death in immediate family, patient's medical emergency). Therefore, management has the discretion of waiving the cancellation fee ***as a one-time exception***.

SERVICE PACKAGES & PRE-PAID TREATMENTS

A 50% down payment is required at the time of scheduling for all pre-paid service packages and pre-paid treatments. The balance must be paid in full at the time of the first scheduled appointment of the package**. If the balance is not paid, scheduled appointments for these services will be cancelled and the 50% down payment will be forfeited.**

Special pricing and discounts aren't allowed to be combined with packages as they are already priced at a discounted rate.

All service packages and prepaid treatments must be used within 12 months of the date of purchase, or they will expire, forfeiting the money paid toward them. You are responsible to contact us prior to the 12-month expiration date to receive a credit for any unused prepaid services. Failure to contact us prior to the 12-month expiration will result in expiration and forfeiture of any non-received services. Special terms could apply to purchases made at our events.

"Cancellation and No-Show Policies" are also applicable to Prepaid Packages.

NO Refunds will be issued for Service Packages or Pre-Paid Treatments. If you are unable to use an un-rendered or pre-paid service, our policy allows for a **ONE-TIME** exchange of the unused portion toward other services in the form of a credit. Any package discounts will be removed, and each session will be charged the original full price per session. A credit will then be issued for the remaining balance and will be good for 12 months from the original purchase (not 12 months from the exchange date) after which, if not used, will be forfeited.

GIFT CARDS

What a Great Way to Show Someone You Care! Gift cards may be purchased in any denomination and used for both surgical and non-surgical services. However, gift cards are non-refundable.

Discounted gift cards **MAY NOT** be combined with any other offer (i.e., Spring Fling/Get Glam special event, or an event with discounted pricing listed).

GRATUITIES

It is not customary to give any kind of monetary tip to your licensed service provider for medical services. The greatest tip we could receive from a client is your repeat business and a great online Google review!

PRODUCT RETURNS
As our products are medical grade and tailored to meet the specific needs of each individual client, a follow up appointment should be scheduled for approximately six (6) weeks later with your skin care provider. At this time, the provider will reevaluate your skin and assess the outcome. Our products are medically supervised, just like a prescription you might receive from a physician, thus they cannot be purchased at any location other than a medical spa.

NO REFUNDS will be given for products purchased. Only defective products may be exchanged for alternative products within fourteen (14) business days of purchase. Opened products will not be accepted for exchange or credit. The same policies and procedures apply to On-line purchasing of products.

* All Centre Yourself Medical Spa Policies, Prices and Services are subject to change without notice *
*** All sales of services and products are final ***
* *

ADDITIONAL POLICIES

CHARGES FOR COPIES OF DOCUMENTS
We understand that from time to time you may require copies of records from this office. Please understand that we have limited resources whose main purpose is to attend to patient needs; therefore, we will need at least three (3) business days to complete your request for copies of documents. Additionally, a charge for the documents will be assessed in accordance with the current State of Indiana's allowable cost (760IAC 1-71-3).

COMPLETION OF FORMS FOR FMLA, DISABILITY, ETC.

If you require completion of documents for application for FMLA, disability, etc., please understand that the healthcare practitioner's time has been scheduled in advance and there is a high likelihood that said forms will not be completed on the day they are received. You should expect at least a thirty (30) business day wait for their completion. Someone from our staff will contact you when the forms are ready to be picked up from the office.

INFORMED CONSENT FOR TELEHEALTH CONSULTATION

I, understand that telehealth includes the evaluation of my medical history, assessment, consultation, and treatment plan. I understand that I have the following rights with respect to telehealth:

1. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is confidential. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. The Centre, P.C. utilizes secure, HIPAA compliant audio/video transmission software to deliver telehealth.
4. I understand that if my provider believes I would be better served by another form of intervention (e.g., face-to-face consultation), I will be scheduled appropriately.
5. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology.
6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that I have a right to access my medical information and copies of my medical records in accordance with the laws pertaining to the state in which I reside.

Please check your appropriate response below:

☐	**I hereby voluntarily give my informed consent** for the use of telemedicine in my medical care. I hereby authorize said provider to use telemedicine in the course of my diagnosis and treatment.
☐	**I hereby DO NOT give my informed consent** for the use of telemedicine in my medical care. I hereby **DO NOT** authorize said provider to use telemedicine in the course of my diagnosis and treatment.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

The practice is committed to protecting the privacy and security of health information as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules, the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), and applicable Indiana privacy and security laws. The practice provides a framework that promotes understanding and compliance with these laws to ensure all employees are well informed of their responsibilities to maintain the privacy and security of patient, employee, and/or subject data.

The practice must use its best efforts to comply with the HIPAA Privacy Rule and Security Standards for protected Health Information as mandated by the Department of Health and Human Services of the United States Federal Government and The Centre, P.C.'s policies and procedures related to this important federal law.

I hereby acknowledge I have been shown The Centre, P.C. Notice of Privacy Practices for Protected Health Information. I acknowledge I have read and fully understand the Notice. I have been provided the opportunity to ask questions about the Notice and my questions have been answered to my satisfaction.

Please check the appropriate box below for your response:

☐	**I AM REQUESTING** to receive a copy of The Centre, P.C. Notice of Privacy Practices for Protected Health Information.
☐	**I CHOOSE NOT** to receive a copy of The Centre, P.C. Notice of Privacy Practices for Protected Health Information.

AGREEMENT TO PAY

I agree to pay for all services and charges rendered to me by The Centre, P.C. If this account is not paid in accordance with The Centre, P.C. policies, I agree and guarantee to pay late fees, collection costs, including reasonable attorney fees, collection agency fees, and interest from the date of demand.

We accept the following forms of payment; use of a combination is acceptable:

- **Cash**
- **Personal Check (see note in "additional notes" regarding returned for insufficient checks)**
- **Money Order or Cashier's Check or Debit Card**
- **Credit Cards: Visa, Master Card, Discover or American Express**
- **Financing Plans:** We accept payment from Care Credit (www.carecredit.com), SmartHealth PayCard (www.SmartHealthPayCard.com), and BHG Lending

NOTICE OF FINANCIAL INTEREST IN HEALTHCARE ENTITY

In addition to the above, I acknowledge with my signature the some of the physicians at The Centre, P.C., are a part-owner of The Centre, P.C., The Centre, L.L.C and Centre Yourself Medical Rejuvenation Spa. The physicians believe the medical spa facilities are an appropriate setting for your medical care. Nevertheless, the selection of a specific healthcare provider always rests with the patient, and you may choose to be referred to an alternative setting if you so desire.

My signature at the end of this document is acknowledging the above terms under the Centre Yourself Medical Spa Procedures and Financial Policies Informed Consent for Telehealth Consultation, Notice of Privacy Practices for PHI, Agreement to Pay, and Notice of Financial Interest in Healthcare Entity.

ADDITIONAL NOTES:
In order to create a calm environment, free from extraneous noise and disruption for all of our patients, we do not allow cell phones, children under the age of 13 (unless they are a patient), or pets of any type or size in the office. Naturally, certified Service Pets are an exception to this policy with accompanying documentation. In the event you arrive for your appointment with a child under 13 years of age who is unsupervised, or a pet which is not a certified service pet, we will unfortunately have to cancel and reschedule your appointment as it will be treated financially as a "No Show".
Client privacy is of the utmost importance to us as a medical provider; therefore, to protect the privacy of all our clients and staff, we do not allow photographing or video recording while inside our facility ANYWHERE.
Please note that all returned checks for insufficient funds will result in a $40.00 fee and in the future only cash or credit card payment will be accepted.

I HAVE READ THIS COMPLETE DOCUMENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS AND HAVE THEM ANSWERED TO MY SATISFACTION. I CLEARLY UNDERSTAND THE MEDICAL SPA PROCEDURES AND FINANCIAL POLICIES OF THE CENTRE, P.C. REGARDING MY SCHEDULED APPOINTMENT AND TREATMENT.

x		x	
Patient Signature	Date	Witness to Signature	Date

If a patient is under 18 years of age or otherwise unable to consent, the following must be completed:

I ____, hereby certify that I am the ____ of the patient, that patient is unable to consent because patient is a minor or because:

____

x		x	
Signature of Parent, Legal Guardian, Patient Advocate or Next of Kin	Date	Witness to Signature	Date