108 Bass Lake Rd. Holly Springs, NC   27540
919-557-6400   www.hsSkin.com

Registration Information: (Please print clearly)

DATE: ___________________

Legal Name:____**Date of Birth**: _____________
First: M.I. Last:

Age: __________________ **Gender**: **M** **F** **Primary Phone**: (__________)_____________________

Other Phone: (__________)_____________________

Address: ____

City: ____ **State**: _______________ **Zip**:_____________________

EMAIL Address: ____

Preferred Pharmacy Name & Location: ____

How did you hear about us/Referred by? ____

Methods of Contact

May we text you? Y N
May we email you? Y N
May we leave you a voice mail? Y N

Authorization For Use or Disclosure of Patient Photographic and/or Video Images

At times, THRIVE SKIN + WELLNESS may request to utilize/disclose your name, photographic or video image and/or testimony for marketing purposes. This could include but is not limited to listing your name as a prize winner, posting a video of you receiving a treatment or a photograph of your before/after results. Often visual aids will have your identifying features obscured so that your identity remains anonymous.

You have the right to allow or not allow THRIVE SKIN + WELLNESS to use these images/likenesses/videos/etc. Please fill out this form according to your choices.

If you authorize THRIVE SKIN + WELLNESS to use or disclose your image/likeness/video/name/etc, sign here:

Authorization:
I authorize the use and disclosure of my name, photographic / video images and/or testimonial for marketing purposes by THRIVE SKIN + WELLNESS. I understand that information/images disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

Purpose:
Names/photographs/video images, and/or testimonials will be used for THRIVE SKIN + WELLNESS Social Media and/or advertising. Social Media includes, but is not limited to, Facebook, Instagram, Twitter, THRIVE SKIN + WELLNESS website, monthly newsletter, and brochures.

Revocability:
I understand that I may revoke this authorization at any time, and that such revocation must be submitted in writing and received by THRIVE SKIN + WELLNESS via delivery requiring signature or delivered to the Practice Manager in Person.

No Treatment Conditions:
I understand that THRIVE SKIN + WELLNESS can not make treatment contingent upon whether or not I sign this authorization.

Patient Name: ____ **Date:** ________________________________

Signature of Patient: ____

If Patient is a Minor or requires a representative:
Representative/Parent/Guardian name: ____

Signature: ____ **Date:**______________________________________

If Representative/Parent/Guardian, what is your relationship to patient: ________________________________

****

If you DO NOT authorize THRIVE SKIN + WELLNESS to use or disclose your image/likeness/video/name/etc, sign here:

I do NOT authorize THRIVE SKIN + WELLNESS to use or disclosure my name, photographic / video images and/or testimonial for marketing purposes.

Signature: ____ **Date:** __________________________________

Medical Information – Please complete entire section

I. Medical History:

Do you have now or have you ever had:

	Yes	No		Yes	No
Active infection or current illness			Headaches		
Alopecia			Hearing Loss		
Anxiety			Heart Attack		
Arthritis			Heart Murmur/Palpitations		
Asthma			Hepatitis/Liver Disease		
Atrial Fibrillation(irregular heartbeat)			Herpes Virus		
Blood thinners, bleeding or clotting disorders			High Blood Pressure(Hypertension)		
			HIV/AIDS		
			Hyperthyroidism		
Bowel Disease/Colitis/Crohn's			Insufficient hemoglobin or low HGB count		
BPH			Kidney/Bladder Problems		
Chemotherapy/ Radiation treatment			Low Fibrinogen or Platelet count		
COPD			Lymphedema		
Coronary Artery Disease			Migraines		
Depression / Psychiatric disorder			Neurological condition (including Stroke, Myasthenia Gravis, or Guillain Barre)		
Diabetes/High Blood Sugar					
(If Diabetic, list last Hbg A1C level)			Pacemaker or defibrillator		
End Stage Renal Disease			Polycystic Ovarian Disease		
GERD			Seasonal Allergies		
Glaucoma			Seizures		
History of any type of cancer			Yeast Infections		
			Other		

If 'YES' to any above, please explain:

II. Family History

Do you have a family history of:	Yes	No
Abnormal ("Dysplastic") Moles		
Allergies/Asthma		
Skin Cancer – Melanoma		
Skin Cancer – Basal/Squamous Cell		
Other Skin Disorder		
Neurologic disorders		
Cardiac disease		
Other Cancers		
Thyroid disease		

III. Females

	Yes	No
Excess Facial/Body Hair		
Regular Menstrual Periods		
Are you currently pregnant or nursing?		

IV. Medications

List **ALL** medications you are taking, including any over-the-counter herbals, vitamins or birth control:

	Yes	No
Are you regularly taking steroids or anti-inflammatories such as Aspirin, Motrin, Ibuprofen or Aleve?		
Have you tried oral antibiotics for acne?		
If yes, for how long?		
If yes, did it help?		
Do you wish to avoid oral antibiotics due to side effects?		
List reactions:		

Acne medications you have tried:

THRIVE
skin + wellness

V. Allergies or sensitivities:	Yes	No		VII. Current Health:	Yes	No

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Are you sensitive / allergic to any oral or topical medication? If Yes, please list:		
Bee Stings		
Herbs/Supplements/Other		
Latex		
Local or other anesthetics (Lidocaine, etc)		
Have you ever had an adverse event from Botox, Dysport or Xeomin?		
Have you ever had an adverse event from dermafiller such as Juvederm or Restylane?		
Have you ever had an adverse event from a laser treatment?		

VI. Dermatologic History: Do you have now or have you ever had:	Yes	No
Abnormal Moles		
Abnormal Scarring		
Acne		
Actinic Keratoses		
Basal Cell Carcinoma		
Blistering Sunburns		
Cold Sores		
Dry skin / Fragile skin		
Eczema		
Flaking or Itchy Scalp		
Hay Fever/Allergies		
Keloids or Hypertrophic scars		
Melasma / Hyperpigmentation		
Permanent makeup		
Poison Ivy		
Poor Wound Healing		
Precancerous Moles		
Psoriasis		
Skin Biopsy		
Skin Cancer or Melanoma		
Skin Pigmentation Problems		
Are you under a doctor's care for any skin condition?		
Have you used or are you currently using any of the following?		
Accutane in past 6 months		
Glycolic Acid products		
Retinoid		

Do you smoke?		
How much?		
Do you drink alcohol?		
How much?		
Do you use a tanning bed?		
If so, how often?		
Do you use drugs?		
How much?		

VIII. Past Surgeries:	Yes	No

Please use this area to list any past surgeries, complications or other information we should know

Cosmetic Surgery: (Please list)

<< Please explain any yes answers to Dermatologic History questions here:

Patient Initial ____________________
Date ____________________________

Provider Initial _____________
Date ______________________

OFFICE POLICIES

THRIVE SKIN + WELLNESS strives to render excellent care to our entire patient community.

To help ensure quality care for everyone, please read our office policies below:

1. **Payments (Cosmetic and Self-Pay):**
   - Full payment is expected at the time of your appointment.
   - Results are never promised nor guaranteed. Before/after photos are for reference only.

2. **Packages/Series**: Packages/Series pricing allows for cost savings to you and are sometimes offered due to special consideration we receive from our suppliers. If you purchase a package/series but then request a refund before the entire series is rendered, we will charge the portion of the series purchased at regular price minus 10%. The remaining payment balance, if any, is the amount of refund we will issue.

3. **No- Show and Cancellations Policy:** We understand that life happens and on occasion, appointments need to be rescheduled or cancelled.
   - A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. All "no-shows" will result in a fee of $50.
   - If it is necessary to cancel your scheduled appointment, we require that you call or text at least 24 hours in advance, or you will incur a $50 charge to your account. To cancel or reschedule appointments, please call or text 919-557-6400 or email info@hsskin.com and leave a detailed message.

4. **Late Arrivals:**
   - A “late arrival” is someone who arrives more than **5 minutes** after their scheduled appointment time or arrives on time without necessary paperwork completed. This causes our schedule to run behind, and more importantly can cut your appointment short with your Provider. A “late arrival” may be asked to re-schedule their appointment. We ask that all new patients arrive 10-15 minutes prior to their appointment time to complete paperwork.

5. **Scheduling Cosmetic Treatments:**
   - As is customary with industry standard, we require a credit card number, which we will hold on file, to schedule any cosmetic consultation or cosmetic treatment appointment. If you “no-show” for this appointment or cancel with less than 24 hours notice, $50 will then be charged to that card as a no-show fee.

6. **Medical Records:**
   - Medical records from another office must be received at least 48 hours prior to the date of your appointment if you wish us to consider them during your visit to THRIVE.
   - Copies of medical records fees are set in accordance with the State of North Carolina. All fees must be paid prior to picking up or mailing medical records.

7. **Returns/Refunds: Products and Services**
   - Any Product may be returned **within 7 days of purchase** for a full refund ONLY if you display an adverse reaction. In order to reduce the chance of a reaction, we recommend you purchase a trial size of the product in which you are interested. This size allows you to try the product before incurring full cost and determine if it will cause a reaction.
   - **If you change your mind about a product purchase, we will ONLY accept unopened products for return.** If the product is returned within 30 days from date of purchase, you will receive store credit for the amount you paid, but no refund will be issued. Beyond 30 days from purchase, no refund or store credit will be granted for any reason.
   - All treatments, services and pre-paid packages are non-transferable and must be used within 18 months from the date of purchase. If you change your mind after purchase, you may request a refund of your pre-paid service, minus a 15% administrative fee, if the request is submitted within 5 business days of your purchase. Any refund request for pre-paid services coming after 5 business days will be denied. At that time, you may receive store credit to be applied to another service or to purchase product(s).
   - All credit balances must be used to purchase services or products within 18 months of date issued. If credit balance remains after 18 months, it will be forfeited, and no refund will be available.

By signing below, I agree to the company’s terms and conditions.

Printed Name: ____

Signature: ______________________________ **Date:** ______________

Use and Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). By signing this form, you acknowledge that our office may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations. You are also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. If you wish to make alternative arrangements, please contact our office.

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below the individuals with whom you authorize our office to discuss PHI which includes but is not limited to your care, details of your appointment schedule, account balances, etc.

I authorize the release of protected health information to the individuals listed below:

Name:______________________________________Phone: (_______)__________________ Relationship: ___________________________

Name:______________________________________Phone: (_______)__________________ Relationship: ___________________________

Name:______________________________________Phone: (_______)__________________ Relationship: ___________________________

You have choices as to how long this authorization is valid.

☐ Check here if you wish the above authorized individual(s) to have access to your PHI until you revoke this authorization in writing.

☐ Check here if you wish the above authorized individual(s) to have access to your PHI for a specific amount of time.

This authorization will be in effect until ____
(Date authorization expires)

_____________________________________ _____________________________________
Patient/Guardian Signature Printed Name of Patient/Guardian

____
Date

I acknowledge that I have read/received Notice of Privacy Practices (Initial here) ________

NOTICE OF PRIVACY PRACTICES
Total Health & Skin Center DBA THRIVE SKIN + WELLNESS
Privacy Officer: Office Manager 919-557-6400
Effective Date: 9/16/13
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. *We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*
How This Medical Practice May Use or Disclose Your Health Information: This medical practice collects health information about you and stores it in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes: Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. We may also email you reminders. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or

transplanting organs and tissues. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public. Proof of Immunization. We will

disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. Fundraising. We may use or disclose your demographic information in order to contact you for our fundraising activities. For example, we may use the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status to identify individuals that may be interested in participating in fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Officer if you decide you want to start receiving these solicitations again. **When This Medical Practice May Not Use or Disclose Your Health Information:** Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.
Your Health Information Rights: Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices. **Changes to this Notice of Privacy Practices:** We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website. **Complaints:** Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

OCRMail@hhs.gov The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.