BODY ESSENCE
& L'IDÉE

Maple Ridge Square

20 Bobby's Way, Suite 104

Staunton, VA 24401

Welcome to Body Essence, in order to better serve you we would like you to provide us with some basic information about yourself.

PLEASE PRINT CLEARLY

*Name*____

Address ____

*City/Zip Code*____

*Phone Circle:(Home/Work/Cell)*______________________________

Birthday ____________________

Anniversary ________________

Please provide an E-Mail if you would like us to send you our Monthly Specials/Newsletter: ______________________________________

May we contact you for confirmation calls? _______

How did you hear about us? (check all that apply)

*Friend (provide name)*____________________ *Website*___ *Radio*___ *TV*___

*Newspaper*___ *Drive-by*___ *Other*______________________________

Thank you, we hope your experience at Body Essence will be relaxing and refreshing.

Patient Profile

Name:__________________________Today's Date:__________DOB:__________Age:_______ Sex:___

Address:_____________________________ City:_______________Zip_________ Phone:_____________

PLEASE CIRCLE OR FILL IN THE APPROPRIATE ANSWER

- Height? _______FT _______IN Weight? ________ LBS
- Are you pregnant or lactating? Yes No
- Do you wear contact lenses? Yes No
- Do you have permanent makeup? Yes No To what area of the face? ______________________________
- Do you currently use or receive waxing? Yes No (Discontinue 7 days before treatment)
- Do you currently have sunburn/windburn/or a red face? Yes No Why? ____________________________
- Are you in the habit of going to tanning booths? Yes No (If within past 14 days, decline treatment)
- Are you applying any topical medications at this time? Yes No Which Ones(s)?______________________
- Are you currently using any topical retinoid prescriptions? Yes No What Strength? _________ For how long?_______ (Discontinue use 5 days before any treatment)
- Are you using Accutane? Yes No For how long? _____________
- Have you ever had a chemical peel or any type of procedure with a medical device? Yes No
  Within 14 days? Yes No Describe____
- Do you have regular collagen, Botox, or other dermal injections? Yes No (Peels may follow after 2 days)
- Have you had facial surgery? Yes No Describe _____________________ How long ago? _______________
- Have you had laser surfacing? Yes No When?_________ What type?______________________________
- What type of work do you do? ________________________ Regular Air travel? Yes No
- Do you participate in vigorous aerobic activity or sports? Yes No
- Do you smoke or use tobacco? Yes No
- Do you develop cold sores or blisters? Yes No
- Are you allergic/sensitive to: (Circle all that apply) Milk Apples Citrus Grapes Aloe Vera Aspirin
  Seafood Perfumes Latex Hydroquinone Mushrooms Lidocaine Other:___________________
- Are you sensitive to alcohol based products? Yes No
- Have you ever used any products that cause a bad reaction? Yes No Describe_________________________
- Are you taking any medication at this time? Yes No What kind?____________________________________
- Are you currently using any mood altering medications? Yes No What kind?__________________________
- What is your Hereditary/Ethnic Background? ____
- Do you consider your skin: Resilient Sensitive Unsure
- Describe your skin: (Circle) Normal Oily Dry Combination Thin Saggy Acne Blackhead
  Whiteheads Freckled Eczema Melasma Mature Wrinkled Sallow Dehydrated Rosacea
  Sun Damaged Large Pores Uneven Red Other:______________________________________
- What skin care products are you currently using at home? Please describe.
  - Cleanser:
  - Toner:
  - Mask:
  - Scrub:
  - Treatment Product:
  - Moisturizer:
  - SPF:
  - Makeup:

Please turn over…

If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort. I further understand that treatment should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatments are contraindicated.

Patient Name____________________________ Patient Signature____________________________

Legal Guardian Name_____________________ Legal Guardian Signature_____________________
(If patient is under 18)

Date___________

FITZPATRICK SCALE

Score	Question	0	1	2	3	4
	What is your eye color?	Light Blue or Gray	Blue or Green	Hazel or Light Brown	Dark Brown	Brownish Black
	What is your natural hair color?	Red or Sandy Red	Blonde	Dark Blonde, Chestnut, Brown	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very Pale	Pale w/ Beige Tint	Light Brown	Dark Brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful Redness, Blistering, Peeling	Blistering, Peeling	Burns Sometimes, Followed by Peeling	Rarely Burns	Never Burns
	To what degree do you turn brown?	Hardly any or not at all	Light Tan	Reasonable Tan	Tan Easily	Turn Dark Brown Quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Resistant	No Problems
	When did you last expose yourself to the sun, tanning bed, or self-tanning cream?	More than 3 months ago	2-3 Months ago	1-2 Months ago	Less than 1 month ago	Less than 2 week ago
	How often is the area you want to treat exposed to the sun?	Never	Seldom	Sometimes	Often	Always

STAFF WILL ADD UP TOTAL

Total Score	Match score with corresponding skin type	Skin Type	Notes:
	0-7 **8-16** **17-25** **26-30** **Over 30**	**I** **II** **III** **IV** **V-VI**	

Acknowledgement of Receipt of
Notice of Privacy Practices

By signing this form, you acknowledge that this Medical Practice, upon request, will provide you a copy of its Notice of Privacy Practices, which is posted in the Waiting Area. This notice explains how your health information will be handled. HIPAA, the new Federal law concerning medical privacy, requires this notice.

I can receive a copy of the Notice of Privacy Practices by requesting same from the receptionist. The Medical Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered.

____

Patient's Signature or Guardian

____

Date Signed

Please provide Name / Relationship / Telephone Number(s) of any individuals that your health information may be provided to, if requested:

____

____

Provider Use Only

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below.

Patient was given the notice _________Yes _________No

Reason signature was not obtained________________________________

____

____

Staff Signature ______________________ Date ____________________

Patient Name:_________________________________ Date:_______________

RUNNING LATE? NEED TO RESCHEDULE?: WE UNDERSTAND THAT UNEXPECTED DELAYS HAPPEN. IN FAIRNESS TO BOTH YOURSELF AND OTHER PATIENTS, IF YOU ARE RUNNING 10MIN OR MORE BEHIND WE MAY CHOOSE TO PERFORM YOUR SERVICE IN THE REMAINING TIME AT FULL PRICE OR RESCHEDULE YOU TO MEET ALL OF OUR CLIENT'S NEEDS TO REMAIN ON SCHEDULE. WE RESPECTFULLY REQUEST A 24-HOUR NOTICE TO CANCEL AN APPOINTMENT TO AVOID A 50% CHARGE OF YOUR SERVICE AND/OR LOYALTY POINT DEDUCTION. Initial ______

PAYMENT POLICY: THE COST OF AESTHETIC SERVICES ARE DUE IN FULL ON THE DATE SERVICES ARE RENDERED. WE ACCEPT MASTERCARD, VISA, AMERICAN EXPRESS, DISCOVER, CARE CREDIT, PERSONAL CHECKS, AND CASH. I UNDERSTAND THAT THESE ARE COSMETIC PROCEDURES AND WILL NOT BE SENT TO MY INSURANCE COMPANY. ALL PACKAGES PURCHASED ARE NON-REFUNDABLE.

Initial______

PRODUCT DISCLAIMER: I UNDERSTAND THAT NO PRODUCT CAN BE RETURNED AFTER IT HAS BEEN OPENED. Initial______

COSMETIC DISCLAIMER: I'M STATING THAT I HAVE BEEN ADVISED THAT THE GOAL OF THE PROCEDURE I HAVE REQUESTED IS IMPROVEMENT IN APPEARANCE, NOT PERFECTION. THERE IS A POSSIBILITY THAT IMPERFECTIONS MIGHT ENSUE, AND THAT THE RESULTS MIGHT NOT MEET MY EXPECTATIONS OR THE GOALS THAT HAVE BEEN ESTABLISHED. IN RELATION TO THIS I KNOW THAT THE PRACTICE OF MEDICINE AND ESTHETICS IS NOT AN EXACT SCIENCE AND THAT, THEREFORE, NO GUARANTEE OR ASSURANCE HAS BEEN MADE BY ANYONE REGARDING THE PROCEDURE WHICH I HAVE HEREIN REQUESTED AND AUTHORIZED. I UNDERSTAND THAT IF DR. CAMPER AND STAFF JUDGES AT ANY TIME THAT MY PROCEDURE SHOULD BE POSTPONED OR CANCELED FOR ANY REASON THEY MAY DO SO. Initial______

PATIENT RESPONSIBILITIES: I AGREE TO FOLLOW THE INSTRUCTIONS GIVEN TO ME BY DR. CAMPER AND THE STAFF AT BODY ESSENCE TO THE BEST OF MY ABILITY BEFORE, DURING AND AFTER A PROCEDURE SO THAT I CAN GET OPTIMAL RESULTS FROM MY PROCEDURE.

Initial______

PHOTOGRAPHY: FOR THE PURPOSE OF ADVANCING MEDICAL EDUCATION AND ADVERTISING, I CONSENT TO PHOTOGRAPHING AND/OR RECORDING OF THE PROCEDURE.

(optional) Initial______

I HAVE AGREED THAT SHOULD I HAVE A COMPLAINT OF ANY KIND WHATSOEVER, I SHALL IMMEDIATELY NOTIFY MY TECHNICIAN AND I FURTHER AGREE THAT ANY CONTROVERSY OR CLAIM ARISING OUT OF OR RELATING TO ANY OF MY SERVICES WITH BODY ESSENCE OR THE BREACH THEREOF, SHALL BE SETTLED BY ARBITRATION IN THE STATE OF VIRGINIA, IN ACCORDANCE WITH THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION AND JUDGEMENT OF THE AWARD RENDERED BY THE ARBITRATOR(S) MAY BE ENTERED IN ANY COURT HAVING JURISDITION THEREOF.

__________________________ ______ ___________________

BODY ESSENCE EMPLOYEE PATIENT SIGNATURE