1301 Plantation Island Drive, Suite 401A
St. Augustine, FL 32080

(904) 461-6060 phone (904) 461-6622 fax

Name: _____
First Middle Last

Address: _____

_____
City State Zip

Birth Date: _____ Age: _____ Sex: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

Cellular Carrier: _____

Email Address: _____

May we email or text you information on discounts and special offers? Y / N

May we **EMAIL** appointment reminders to your email? Y / N

May we **TEXT** appointment reminders to your phone? (Include carrier above) Y / N

Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about us? _____

*PLEASE FILL OUT ALL OF THE FOLLOWING *

Medical History:

Family Physician- Name & Phone Number:

_____

List any medical conditions for which you are presently being treated or have been treated:

_____

_____

_____

List any surgical history and any complications including dates and anesthesia:

_____

_____

_____

Name: _____

First Middle Last

(Continued)

Do you have a history of cold sores? Y / N

Have you had cosmetic procedures or surgery (including fillers, Botox, lasers)?

_____

When and what type?

_____

_____

Allergies: (including prescriptions, over-the-counter medications, latex, etc.)

_____

Medication History:

List any medications, vitamins, and over-the counter drugs you are presently taking & dosages:

_____

_____

_____

Have you taken any steroid preparations over the past year?

_____

Have you taken any Accutane therapy over the past 18 months?

_____

Social History:

Do you smoke or have you smoked in the past? Y / N If so, how much per day?_____

If you **quit** smoking, when did you quit?_____

Do you drink? Y / N If so, how many per day?_____

Cosmetic History:

What area(s) of the face are you interested in having cosmetically improved?

_____

Please indicate the products you use (Cleanser, toner, moisturizer, etc.):

_____

Have you ever used any of the following?

- ☐ Retina A - When? _____ Reaction? _____
- ☐ Glycolic Acid - When? _____ Reaction? _____
- ☐ Other: _____When? _____ Reaction? _____

AVANTI Medical Spa

1301 Plantation Island Drive, Suite 401A • St. Augustine, FL 32080
(904) 461-6060 phone • (904) 461-6622 fax

Financial Policy

PLEASE READ ALL OF THE FOLLOWING:

Welcome to Avanti Medical Spa, LLC!
Our goal is to provide you with quality, state-of-the-art patient care in a cost effective manner. In order to maintain that goal we have established the following policies to improve communication regarding appointments, medical records, and your financial responsibility at the time of service or prior to any scheduled appointment. If you have any questions, please feel free to ask a staff member.

CONSULTATIONS: Our consultations include a Visia Complexion Analysis, detailed evaluation and treatment plan. Avanti Medical Spa charges $50 per consultation with the physician, which is collected prior to the consultation. This fee may be applied to any procedure or product purchased the same day as the initial consultation. Consultations with our Aesthetician are complimentary.

APPOINTMENT RESERVATION FEE: It is our policy to charge an appointment reservation fee for specific medical spa treatments and services. This fee will be collected at the time of scheduling to reserve your appointment time. This fee will be applied to your services. The fees are as follows:

- Botox, Xeomin or Cosmetic Fillers- $50 reservation fee
- Fraxel- 20% pre-payment

MISSED APPOINTMENTS/LATE CANCELLATIONS: Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your cosmetic consultations. In the event that you cancel in less than the requested 24 hours, the $50 reservation fee will be non-refundable. Our office understands that emergencies do arise, but please call our office to discuss this with a staff member.

REFUNDS: All Sales are Final and no refunds will be provided under any circumstances. If you elect not to have a pre-paid procedure performed, the remaining balance can be applied to another product or service.

PATIENT CALLS/MESSAGES: The practice maintains an automated attendant with voice mail. We make every effort to answer patient calls as they come in, however if the staff member you are trying to reach is not available, please leave a message. **It is not necessary to leave several messages.** Patient calls are handled in order of priority within 48 hours. If you are experiencing an emergency and unable to reach a staff member, please go to the nearest emergency room.

Care Credit: If you are interested in setting up a payment plan you can apply for Care Credit. If you are interested in applying for care credit please discuss this with the aesthetician at the time of service.

Return check fee: There will a $50 charge for returned checks. IF A CHECK IS RETURNED, FUTURE CHECKS WILL NOT BE ACCEPTED.

PATIENT DISMISSAL: Failure to observe these policies, demonstration of unacceptable behavior, or medical non-compliance can result in dismissal from the practice

Patient Disclaimer: By signing below, you also acknowledge that the suggested number of treatments, vials or units is only an estimate. To achieve your desired look, you may require more than the original suggested amount.

I have read, acknowledge the above and hereby understand and agree to the financial policies of Avanti Medical Spa, LLC.

Patient Name: _____

Signature: _____ **Date:** _____

AVANTI
Medical Spa

Acknowledge of Receipt of Privacy Notice for Avanti Medical Spa, LLC

1301 Plantation Island Drive, Suite 401A
St. Augustine, FL 32080

(904) 461-6060 phone (904) 461-6622 fax

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

We are required by law to make available to you a copy of our Notice of Privacy Practices. A copy is available for you at the reception window and you may take this copy with you if desired. Please sign below to acknowledge that a copy of our privacy practices was made available to you.

_____ _____
Signature of Patient or Legal Guardian Date

You may authorize certain individuals to be involved in your care. This consent for disclosure includes both health and financial as it relates to your care. Below you may list those individuals for which our office is allowed to release your Protected Health Information.

Individual's Name (Please Print) ***Relationship to Patient***

_____

_____

_____

_____

_____ _____
Your Signature is Needed for Permission Date

AVANTI Medical Spa

Cosmetic Questionnaire

for Men & Women

Date: _____ Name: _____DOB:_____

We offer a variety of non-invasive skin care and supplement options for ***Men and Women.***

Please check all concerns that apply in order to help customize the perfect solutions for you.

What would you like to improve about your skin and/or health?

☐ Wrinkles or Fine lines	☐ Hormonal Breakouts	**Weight Loss and Supplements:**
☐ Expression Lines	☐ Large Pores	☐ Weight Loss
☐ Volume loss- cheeks or lips	☐ Acne	☐ Increase energy
☐ Sunken Eyes	☐ Uneven skin tone/texture	☐ Immune support
☐ Facial resurfacing	☐ Dry Skin	☐ Cardiovascular support
☐ Freckles or Discoloration	☐ Oily Skin	☐ Skin, hair and nail health
☐ Scarring or Stretch Marks	☐ Redness	☐ Improved mood
☐ Loose or Sagging Skin	☐ Short Lashes	
☐ Aging Hands	☐ Other	

1.) Are you currently using any skin care products? Y / N

- If yes, what products are you using? _____
  - What do or don't you like about your products? _____

2.) Are you currently using any supplements, vitamins, or weight loss options? Y / N

- If yes, what products are you using? _____
  - What do or don't you like about your products? _____

3.) Would you like our doctor and/or staff to discuss products, procedures, weight loss and/or supplement options? Y / N

For in office use only: