801 W Main St, Suite 1C
Bozeman, MT 59715
Ph. (406) 219-3631
Fax (406) 760-1809
www.ElevateHealthMT.com

GENERAL INTAKE

Name: _____ **Date of Service**:_____

Age: _____ **Date of Birth**: _____ **Gender**:_____

Address:_____

City:_____ **State**:_____ **Zip**:_____

Phone Numbers:

Please write number in the space provided	May we contact you at this number?	Can we leave messages for you at this number?
Home:	☐ Yes ☐ No	☐ Yes ☐ No
Work:	☐ Yes ☐ No	☐ Yes ☐ No
Cell:	☐ Yes ☐ No	☐ Yes ☐ No

Text Messages:
May we send you text messages including appointment reminders? ☐ Yes ☐ No

(If you opt in, we will send you text message appointment reminders when you have scheduled an appointment at Elevate Health. You can opt out at any time by contacting our reception at 406-219-3631. Agreement to receive a text message is not a condition of purchasing a good or service. Message and data rates may apply.)

Email:
Email Address:_____

May we contact you at this email, including sending you appointment reminders? ☐ Yes ☐ No

Would you like to be added to our email newsletter?: ☐ Yes ☐ No

Emergency Contact:

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____

How did you hear about Elevate Health?_____

Acknowledgment of Receipt of Notice of Privacy Practices
I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Elevate Health on this date.

_____ _____ _____ _____
Patient's Signature Date Parent/Guardian's Signature Date

_____ _____
Print Patient's Name Print Parent/Guardian's Name

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Acknowledgment of Responsibility for Payment and Payment Agreement

Welcome to Elevate Health. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read the following statements and sign below.

Payment: Payment for all services and medicinary items are due at the time of the visit. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a $35.00 NSF fee.

Phone calls and emails: Phone calls and emails regarding an existing health issue that require more than 5 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Email replies that require more than 10 min of the doctor's time are $35. Phone calls are $65 per 15 min increment, billed in 15 min increments.

After hour calls: For non-life threatening health related emergencies you may reach your physician by calling the clinic and leaving a message marked "urgent" and stating you would like a call back. A $75.00 charge will be applied for pages to your physician. Additional charges maybe applied for additional services beyond responding to the page.

Late cancelations: We require 48-hour notice for canceling any appointments. There is a charge of 50% of the service cost incurred when less than 48-hours notice is given.

No shows: You will be charged the cost of any scheduled visit that you neglect to come to without a call to alert the clinic that you will not be able to make the visit. Special exceptions will be made for extenuating circumstances.

Supplements: Your health care provider may prescribe supplements, which may be purchased at the clinic or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

Pharmacy prescriptions: Your health care provider may prescribe medications, which will be sent to the pharmacy of your choosing if possible. When you are due for a refill of these prescriptions please contact the pharmacy directly and they will send your doctor the refill request. A visit may be required for medication refill.
I have read and understand the above-stated policies of Elevate Health and will comply with them in all respects. I understand that I am financially responsible for the services provided to me by Elevate Health regardless of insurance coverage. If my insurance company requires release of my medical records, I hereby give my permission by signing this form. I also certify that I have read the Notice of Privacy Practices and understand that disclosure of my protected health information may be necessary to secure payment for health care services.

_____ _____

Patient Signature Date

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

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SKIN CARE INTAKE

Name:_____ DOB:_____ Date:_____

What are your top skin concerns at this time?

1. _____
2. _____
3. _____

Medical History:

Are you pregnant? ☐ Yes ☐ No ☐ Maybe Are you breastfeeding? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Please list current health conditions:_____

Please list past surgeries:_____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No; If yes, date of last treatment:_____

Current Medications: Please list any prescription medications, over-the-counter medications, **including topical prescriptions**: _____ _____ _____ _____ _____

Skin Conditions: Do you currently have or have you ever had any of the following?

☐ Skin Infection	☐ Keloids/Excessive Scarring	☐ Herpes (cold sores)	☐ Diabetes
☐ Skin Cancer	☐ Tattoos/Permanent Makeup	☐ Poor Healing	☐ Psoriasis
☐ Easy Bruising	☐ Lymph Nodes Removed	☐ Rosacea	☐ Eczema

Allergies: Are you hypersensitive or allergic **internally or externally** to (include aspirin & iodine):

Any drugs? ☐ Yes ☐ No_____

Any foods? ☐ Yes ☐ No_____

Any environmental or chemical allergens? ☐ Yes ☐ No_____

Previous Treatments:

Treatment	Yes	No	Last Treatment	Any complications?
Facials	☐	☐		
Microdermabrasion	☐	☐		
Chemical Peels	☐	☐		
Waxing	☐	☐		
Tanning	☐	☐		
Laser Therapy	☐	☐		
Massage	☐	☐		

Skincare:

What type of skin do you have? ☐ Dry ☐ Oily ☐ Normal ☐ Acneic ☐ Combination

What is your skin routine? *(Indicate any cleansers, toners, serums, moisturizers, masques, etc.)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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Please Initial:

_____ I agree that the nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been explained to my satisfaction.

_____ I understand that with any treatment certain risks are involved and that any complications from known or unknown causes could occur.

_____ I understand that possible side effects include, but are not limited to: mild to moderate redness, mild to moderate peeling or flaking, stinging, dry skin, tenderness, pimples, cold sores or allergic reactions. Most side effects are temporary and will dissipate within 3-7 days.

_____ I do not have active cold sores.

_____ I will call to inform my esthetician of any complications or concerns I may have as soon as they occur.

_____ I understand that it is recommended prior to having a facial infusion to not have used Retin A for 72 hours, Accutane with the past 6 months or have waxed 24 hours prior to receiving treatment.

_____ If there are changes in my skin care I agree to notify my Esthetician prior to futer treatments.

Client's Signature	Date	Guardian/Representative's Signature	Date
Client's Name		Guardian/Representative's Name	

To be completed by your esthetician

By initialing the client initials box below I agree that the above statements are still true for today's treatment.									
Tx Date									
Client Initials									
Esthetician Initials									

Notes:

I have reviewed the treatment and post care instructions to the client stated above and answered any questions.

Esthetician Signature	Esthetician's name	Date