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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SUGARING INTAKE

Name:_____ DOB:_____

Do you see any of our other providers at Elevate Health? ☐ Yes ☐ No
If so, who?_____

1. What area(s) would you like sugared? (upper lip, bikini etc.):_____

_____

2. Have you used any Alpha Hydroxy Acids, glycolic or exfoliating products in the past 48-72 hours? ☐No ☐Yes

3. Are you using Retin-a, Renova or Accutane (an oral form of Retin-a)? ☐No ☐Yes

4. Are you using any other skin thinning products and/or drugs? ☐No ☐Yes

5. Are you exposed to the sun on a daily basis or are you considering spending more time in the sun soon? ☐No ☐Yes

6. Do you use a tanning bed? ☐No ☐Yes

7. Are you diabetic? ☐No ☐Yes

8. Are you currently taking medications? If so, please list all (including over-the-counter medication and supplements):_____

_____

_____

9. What skin products do you regularly use on your skin?_____

_____

_____

10. Have you ever been treated for cancer? If yes, when and what types of therapies were used?_____

_____

_____

_____

11. Please list any other illness/condition you are currently being treated for by a medical professional:_____

_____

_____

_____

ALLERGIES: Are you hypersensitive or allergic to any medications, foods, chemicals or other allergens?

☐ No ☐ Yes_____

Female clients please note: Because of water retention and higher pain sensitivity during menstruation, for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed (always allow five days for menstrual cycle).

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Please note that sugaring does have certain side effects such as, redness, swelling, tenderness, etc.

I have read the above and if I have any concerns, I will address these with the esthetician. I give permission to the esthetician to perform the sugaring procedure we have discussed and will hold her and Elevate Health, LLC harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand the esthetician will take every precaution to minimize or eliminate negative reactions as much as possible.

I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by the esthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding the treatment or suggested home product/post-treatment care, I will consult the esthetician immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the esthetician, or Elevate Health, LLC responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today. I will inform the esthetician if anything changes within the year.

_____

Client Name (please print)

_____ Date:_____

Client signature