



9001 Forest Crossing Drive, Ste. D-2
The Woodlands, Texas 77381
Ph. (281) 465-9209
Fax ( 281) 651-4875

Aesthetics Patient Questionnaire & History

Name: (Last) (First) (Middle) DOB:

Address: City: State: Zip:

Hm Ph. #: Cell Ph #: Occupation:

Email Address:

How did you hear about us?

Emergency Contact: Relationship: Phone #:

Past Medical History

Medical Conditions (Check all that apply)
Hypertension Heart Disease Thyroid Imbalance High Cholesterol Diabetes Hormone Imbalance PCOS Herpes or Cold Sores
Depression Anxiety Cancer Blood Clotting Abnormalities Pacemaker HIV/AIDS Epilepsy/Seizures Keloid Scarring
Eczema Psoriasis Hepatitis
Other:

Have you ever experienced the following? (Check all that apply)
Facial Microdermabrasion IPL- Photo Facial Tattoo Removal Microneedling Silk Peel
HydraFacial Botox Fillers Vein Removal Laser Hair Removal Skin Resurfacing Chemical Peel
Other:

Do you suffer from any of the following problems?
Whiteheads Blackheads Rosacea Age Spots Hyperpigmentation Hypopigmentation Scars Ingrown Hairs
Stretch Marks Oily Complexion Dry Skin Acne Fine Lines/ Wrinkles Broken Capillaries Hair Loss

List Medications (Accutane, photosensitive medication, antibiotics, etc.):

List Allergies to medications or latex:

What Topical medications or creams are you currently using? RetinA, Other:

Skincare Products currently using:

Alcohol Use: No Yes ( If yes, how often?) Tobacco Use: No Yes ( If yes, how often?)

Have you had any recent tanning or sun exposure that changed the color of your skin? No Yes

Have you recently used any self- tanning lotions or spray tanned? No Yes (If yes, when was the last application?)

Are you pregnant or breastfeeding? No Yes

Have you taken Accutane in the past 6 months? No Yes (If yes, what was the date of the last dosage?)

I understand that I am financially responsible for any balance & payment that is due at the time of service. We are not contracted with any insurance companies for reimbursement and do not file claims. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.
I understand, Optimal Hormone Health & Wellness (OHHW) does not offer refunds, OHHW may offer spa credits towards services not performed with manager's approval.

Blank line for signature or name

Patient Signature Print Name Date



## Office Policies and Procedures for Patients

(Please Initial in the spaces provided and sign the bottom)

### HIPAA Information and Consent Form:

\_\_\_\_\_ I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM, a copy of which has been provided to me by OHHW and any subsequent changes in office policy. I understand that this consent shall remain in force from this date forward.

### Financial Policies

\_\_\_\_\_ ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE.

Payment is required at the time services are rendered unless other arrangements are made in advance. We accept cash, VISA, MasterCard, Discover and American Express.

### Late Arrival

\_\_\_\_\_ It is our goal to provide quality time and care to each patient. While we understand there may be some things out of our control, we encourage you to be ON TIME for appointments. Late arrivals may interfere with another patient's care. We will do our best to accommodate you if you are running late but depending on scheduling, it may be necessary to reschedule.

### No Show

\_\_\_\_\_ A "no show" is someone who misses an appointment without calling or fails to give 24-hour notice. Three (3) "no shows" within a calendar year may result in loss of service. You will also be billed a "no show" fee in the amount of \$50.00 if you are unable to provide our office 24-hour notice.

### Refund Policy

\_\_\_\_\_ Optimal Hormone Health & Wellness does not offer refunds on services. We may do a spa credit for services not performed on your account towards spa services only with manager's approval.

### Product Return Policy

\_\_\_\_\_ Our policy allows you 14 days from the purchase date to return a product with which you have had an adverse reaction. If you have a reaction to the product and would like to return it, you will need to complete and "Adverse Reaction Form." The original receipt must be present for a full refund; you will receive a spa credit without a receipt.

### Patient Safety Policy

\_\_\_\_\_ Due to our Insurance policy and the safety of our patients, only the patient receiving treatment will be allowed in the treatment room. Any guests accompanied with the patient over the age of 18 will have to wait in the waiting area.

### Policy regarding Children

\_\_\_\_\_ Children under the age of 12 are not allowed in the Spa area of the clinic. Optimal Hormone Health & Wellness will need to reschedule your appointment for a later date if a patient is accompanied with a child under the age of 12.

I have read and understand Optimal Hormone Health & Wellness' policies regarding its services.

Patient Name (Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## Reservation and Cancellation Policy

Spa services are available by appointment only. All services must be guaranteed with a major credit card to reserve your appointment. We recommend booking reservations in advance and will do everything possible to honor your request and time. Appointments are booked based on availability. We recommend scheduling your appointment one or two weeks in advance to ensure availability.

### 24- Hour cancellation policy:

We aim to provide our patients the highest quality service and we pride ourselves on our exceptional staff. If you cancel within less than 24 hours of your scheduled appointment, we not only lose your business, but also the potential business of other patient who could have taken your scheduled appointment time. For this reason, we are still obligated to compensate our staff for their time as well as make up for our lost revenue.

Same day appointment cancellations less than 24-hour notice will be charged \$25.00. No-show appointments will be charged \$50.00. If a credit card is declined for cancellation/ no-show transactions, that appointment will count as services rendered/ forfeited. This ensures all other guests the opportunity to enjoy our services. To cancel your appointment, you must speak to an employee directly. If you cannot speak with an employee, you must leave a detailed voice message or an email to [info@ohhw.org](mailto:info@ohhw.org).

**Failure to give credit card information will not have the option for the \$25 or \$50 fee; late cancellation or no-show appointments will count as services rendered/forfeited.**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Todays Date: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Exp. Date: \_\_\_\_\_

CVC Code: \_\_\_\_\_ Zip Code: \_\_\_\_\_



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It is the policy of Optimal Hormone Health & Wellness (OHHW) to protect its patients, within reasonable limits, from invasion of privacy that might occur from the use of photography, videotaping, digital imaging, and other visual recording during patient care or other health system activities. Consent must be obtained before any patient may be photographed. Specific written authorization must be obtained before any patients photograph will be released.

In facilities where patient photography is used routinely to document patient care, the practice of patient photography in healthcare operations should be included in the HIPAA- mandated notice of information practices, as well as in the consent for treatment signed on admission.

I understand that photographs, videotapes, digital or other images may be recorded to document my care and I consent to this. I understand that OHHW will retain the ownership rights to these photograph, videotapes, digital or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in OHHW's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from myself or my legal representative.

### **Disclosure**

Unless otherwise required by federal or state law, photographs, videos, scans or other images shall not be released to outside requestors without specific written authorization from the patient or his or her legal representative.

Please initial all that apply:

\_\_\_\_\_ Photographs for file only.

\_\_\_\_\_ Photographs for educational use.

\_\_\_\_\_ Photographs for advertisement.

Patient Printed Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_