TRIPOLLAR

General Information Form

(Please print legibly)

Last Name: _____ First: _____ Middle: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

E-mail Address: _____ Preferred Method of Contact: _____

Primary Care Physician: _____ Phone Number:_____

Physician Address: _____

Emergency Contact: Name:_____ Phone number: _____

Relationship:_____

How did you hear about this program? (please be as specific as possible)

☐ Internet ☐ Magazine ☐ Newspaper ☐ Billboard ☐ Friend. If so, who? _____

☐ TV: ☐ WAFF 48 ☐ WHNT 19 ☐ WAAY 31 What TV Program? _____

Occupation: _____ Employer: _____ Retired: ☐ Yes ☐ No

Current Prescribed Medications, Over- The- Counter Drugs, Dietary supplements

Name Strength

Quantity / Dosage

_____

_____

_____

_____

Please indicate in your own words what concerns you :

_____

_____

_____

_____

Health Questionnaire

Please check and answer all that are applicable:

Do you use sunscreen?	Yes	No	
Are you currently Pregnant?	Yes	No	
Are you currently Nursing?	Yes	No	
Do you drink Alcohol?	Yes	No	Frequency_____ years of use_____
Do you smoke?	Yes	No	Frequency_____ years of use_____
Have you Quit Smoking?	Yes	No	Frequency_____ years of use_____ _____
Have you ever had blood clots?	Yes	No	

Do you suffer from Rheumatoid Arthritsis? Yes No

Do you have Autoimmune Disease? Yes No

General: Please check all that apply.

1. ( ) HIV
2. ( ) Recent Weight Gain _____
3. ( ) Recent Weight Loss _____
4. ( ) Dye Allergies
5. ( ) Codeine
6. ( ) Aspirin
7. ( ) Nitrate Allergy
13. ( ) Seasonal Allergies
14. ( ) Other

Skin Conditions/Diseases: Please check all that are applicable.

( ) None ( ) Keloid Scarring ( ) Cancer

( ) Herpes (Cold Sores) ( ) Abnormal Wound Healing ( ) Depression

( ) Skin Cancer ( ) Eczema ( ) Dry/Fragile Skin

( ) Diabetes ( ) Rosacea
( ) Hormone Related Issues

( ) Acne ( ) Heart Disease ( ) Pigmentation Problems

( ) Psoriasis ( ) Rash
( ) Other (Please list below)

_____
_____
_____

Have you recently had surgery or invasive procedure in the area you are interested in treating?

_____

_____

Do you have a metal implant in the treatment area?

_____

_____

Do you have Gold Threads

_____

_____

Condition you would like improved:

Wrinkles?		No	Where_____
	Yes		
Pigmentation		No	
Problems, Acne?	Yes		
Cellulite?		No	Where
	Yes		_____

Have you ever had or used:

( ) Retin A **( ) Chemical Peels** **( ) Botox**

( ) Microdermabrasion **( )Restylane** **( ) Accutane**

( ) Herpes Medication **( ) Antibiotics for Skin** **( ) Oral Contraceptives**

Current skin care regimen:

Cleanser _____

Toner _____

Scrub _____

Exfoliator _____

Sunscreen _____

Moisturizer _____

Other _____

Please initial the following statements that pertain to you:

I hereby agree that I understand and have answered all the questions to the best of my ability. __initial here__

I understand it is my responsibility to inform my Primary Care Physician of my current weight loss program. __initial here__

For patients who have High Blood Pressure and/or Diabetes (Type 1 or Type 2):

I understand that my current medication was prescribed at my current weight and as my weight decreases my medications may need to be adjusted. __initial here__

I agree to keep track of my blood pressure and/or blood sugar levels in my patient journal and notify my primary care physician of my levels. __initial here__

I understand that as I lose weight "fat" that I should postpone any blood lipid test (cholesterol) as my results will be inaccurate for 3-4 weeks after completing the program. __initial here__

For Female Patients:

Do you use birth contr□l? □Yes No Have you gone through□men□pause? Yes No

I understand that in the event I miss my period and a pregnancy test resulted in a positive. I will need to place my weight loss program on hold for 2-3 days and then retest for pregnancy. In the event of pregnancy, Bouari Clinic recommends you immediately discontinue your weight loss program __initial here__

Authorization and Consent of Parent(s) or Legal Guardian(s) for Minors:

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant my authorization and consent for _____ to be on The Bouari Clinic Program. By signing this document I do confirm that I personally am responsible for monitoring my child throughout the length of The Bouari Clinic Program. I understand that Bouari Clinic is not responsible in any way for my child's participation, and that I am taking sole responsibility, as her Parent(s) or Legal Guardian(s), to ensure she/he is following the protocol to the specifications laid out in the patients journal that I have received and have reviewed with my health consultant. If at any point in time I see any medical concerns I will contact Bouari Clinic immediately and I will be subject to removing my child from the program, If a Bouari Clinic Medical Director or my child's Primary Care Physician sees fit.

It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of Bouari Clinic in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective as of this _____day of_____, 20 ____.

Parent(s) or Legal Guardian(s) Signature: _____

Please initial one of the following:

*Please note Bouari Clinic will not use your before or after photos for any form of advertisement without your consent. Before and after photos sole purpose is for you as the patient.

□ Ye□ No **I authorize Bouari Clinic to take my before and after photos.**

Confidentiality Statement

Your health is a serious personal matter and we understand that confidentiality is of utmost importance. To ensure your complete privacy, we implemented and follow specific strict security protocols and processes.

We use the highest level of customer and web site security features to guarantee your privacy and security. It is our policy to never allow any 3rd party access to any of your personal financial or medical information. If you have a question on our security processes or protocols please contact us immediately.

HIPAA: Health Insurance Portability and Accountability Act

This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review this carefully.

In compliance with the 1996 Congressional act to protect the privacy of patients' protected health information, we will safeguard all client/patient information and will disclose or share only minimal information necessary for the following purposes:

Treatment: Information regarding current or past health information necessary for any agency to carry out appropriate care of the patient requesting services which may include but is not limited to: History and physical, progress notes, laboratory reports, consultation reports, to be obtained from any clinic, hospital, skilled nursing facility, physician office or health care agency involved in the patient / client's present future care.

Payment: Information requested by the insurance company, necessary for the processing of claims for payment of services.

If you feel that your privacy rights have been violated you may contact us and ask for the Director of Professional Services. The director will investigate all claims and will provide you with a written report of their findings within 10 days. If you are not satisfied with the report and corrective action taken, the Director will provide you with an appropriate state or federal organization address and or telephone numbers to file a complaint.

We will maintain a log for each patient we service which will list what information was released and for what purpose. The patient has the right to review this log upon request. Your privacy is important to us and we use every care to secure your privacy rights!

By initialing here, you understand that once a program has been paid and used it is Bouari Clinic's policy that your program is **non-refundable**. __initial here__

Patient Signature _____

Date_____