RJ EDWARDS
AESTHETIC CLINIC

Brilliant Distinctions Rewards

This form is considered Personal Health Information (PHI) and therefor is protected by United States legislation that provides data privacy and security provisions for safeguarding medical information, also known as HIPAA. The information will be used exclusively for generating, or searching for, your Brilliant Distinctions account.

Brilliant Distinctions is a program started by Allergan (the company which produces BOTOX®) that allows patients to earn cash and point bonuses for every treatment they receive with Allergan products (such as BOTOX® and many fillers). The program is entirely confidential and requires no work from patients, however, at any time, you can the only person who can access the account. A Brilliant Distinctions account is solely there for you to earn rewards for the treatments you receive. Please ask the office manager if you have any questions about Brilliant Distinctions® and/or awards you may be eligible for today.

Name _____ Date _____
(First) (Middle) (Last)

Sex: Female ☐ Male ☐ Birthday: _____/_____/_____
(Month) (Day) (Year)

Address: _____
Street Address (City) (State) (Zip Code)

Email Address: _____

Internal Use Only

Acct	New	Pts	Log	
BD	|Y|N|	|Y|N|	# :	Pmt : |CC |Cash|
Aspire	|Y|N|	|Y|N|	E :	Skd : |Y|N|
				Event : |Y|N|
				Promo : |Y|N|

R J EDWARDS
AESTHETIC CLINIC

Patient Information

Name_____ Date _____
(First) (Middle) (Last)

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is confidential.

Birthdate: _____ Sex: F___ M___

Address: _____
(Street: If mailing address is PO Box, Street Address is required also) (City) (State) (Zip Code)

Phone # with area code: _____|_____|_____
(Home) (Cell) (Work)

Email Address: _____ Contact with Promotions: Yes____ No____

Employer: _____ Occupation: _____

Emergency Contact

Full Name: _____ Relationship: _____

Address: _____|_____|_____|_____
(Street) (City) (State) (Zip Code)

Phone # with area code: _____|_____|_____
(Home) (Cell) (Work)

How did you find out about us? _____

If referred, please provide: Name_____
(First) (Last)

Cancelation Policy

We understand that a situation could arise that could cause you to postpone your consultation appointment. Please contact our office within 24 hours of your appointment time to reschedule.

R J Edwards Aesthetic Clinic, LLC reserves the right to charge for late cancellations or multiple missed appointments. In the event of more than 3 missed appointments or at the discretion of R J Edwards Aesthetic Clinic we reserve the right to request a payment be made to secure an appointment which once attended, the cost of which will go toward your treatment cost, or, if not attended, will be kept to compensate for repeated financial losses due to missed appointments.

Privacy Practices

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information. You are being provided with a copy of the **Summary of the HIPAA Privacy Rules.** Please sign below acknowledging you have been offered a copy of the **Summary of the HIPAA Privacy Rules.**

Signature: _____ Date _____

RJ EDWARDS
AESTHETIC CLINIC

Medical/Surgical Health History

Name_____ Date _____
(First) (Middle) (Last)

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is confidential.

Age_____ General Health *(please circle)*: *Poor* *Fair* *Good* *Excellent*

Height	*Current Weight*	*Goal Weight*	*Weight Changes in Past Year?*	*Was it Weight Gain or Loss?*

Please List Allergies of any kind (foods, medications): _____

_____

_____

Current/Recent Medications:
Please check boxes where the answer is yes

- ☐ Are you currently taking birth control pills?
- ☐ Do you take an aspirin daily?
- ☐ Do you take anti-inflammatory medications such as Motrin, Aleve, Naproxyn or Mobic?
- ☐ Are you currently using Retin-A or Tretinoin?
- ☐ Are you currently taking supplements such as fish oil?
- ☐ Please list all medications you are taking, including herbal preparations and supplements:

_____

_____

- ☐ Are you presently under a physicians or practitioners care for any condition? If so please describe:

_____

_____

Lifestyle Information:
Please check boxes where the answer is yes, use extra space to specify if needed

- ☐ Do you consume alcohol? _____
- ☐ Do you currently, or have you ever, smoke(d)? If you quit, how long in the past _____
- ☐ Do you exercise regularly? _____
- ☐ Do you use tanning booths? _____
- ☐ Do you have a history of sun exposure? If so please describe: _____

_____

Cosmetic History
Please check boxes if you have had the treatment before

- ☐ Dermal Fillers & Injectables (Juvederm, Restylane, Radiesse, Sculptra, Kybella)
- ☐ BOTOX® / Dysport®/ Xeomin®
- ☐ Chemical Peels
- ☐ Laser Treatments
- ☐ Microneedling

RJ EDWARDS
AESTHETIC CLINIC

What conditions currently apply to your skin?

Please circle all that apply

Uneven skin tone	Hyperpigmentation	Acne / Acne scars	Facial hair
Facial capillaries	Sagging skin	Enlarged pores	Lip lines
Age spots	Fine line / Wrinkles	Loss of volume	

What would you like to achieve with your treatment and/or skin care?

_____

_____

What is your current skin care regimen?

Morning	Evening	Other

Please mark if you have or have had any of the following medical conditions:

Diabetes		Bleeding Problems (low platelet count, hemophilia, blood disorder)		Blood thinning medications: (please list any you take below)
High Blood Pressure				
Mitral Valve Prolapse		Have a surgical implant of any kind (especially present in in the face or hands)		
Neuromuscular Disease				
Heart Palpitations				
Heart Disease		Planning pregnancy in near future		
Asthma		Cancer		
Lung Disease		Depression		
Are you pregnant		History of cold sores or herpes		

Any other medical conditions? If yes, please explain: _____

_____

Surgical History: _____

_____

Family Medical History:

Tuberculosis		High Blood Pressure		Blood Disorder	
Lung Disease		Heart Disease		Blood Clots	
Asthma		Diabetes		Epilepsy/Seizure Disorder	
Neuromuscular Disease		Kidney Disease		Mental Health Disorder	
Cancer					

I attest the above information to be true, knowing my provider relies on this information to provide safe and effective treatments.

Signature: _____ Date _____

RJ EDWARDS
AESTHETIC CLINIC

Cosmetic Interest Questionnaire

The following questions are on a scale of 1 – 5 (1 = not at all concerned; 5 = very concerned)

1. As I've aged, I am more concerned about fine lines and wrinkles around my eyes and forehead (circle a number). 1 2 3 4 5
2. As I've aged, people incorrectly perceive me as looking angry, tired, or sad, even when I'm not (circle a number). 1 2 3 4 5
3. I am concerned about the differences and changes in the color, tone, and texture of my skin (circle a number). 1 2 3 4 5
4. I am concerned about acne, acne scarring or scars from surgery or injury (circle a number). 1 2 3 4 5
5. Excess skin around my face, neck and body is problematic and unattractive (circle a number). 1 2 3 4 5
6. I am concern about the appearance of my toenails, thickening or discoloration (circle a number). 1 2 3 4 5
7. I am concerned about the extra fat below my chin (circle a number). 1 2 3 4 5
8. I am concerned about excessive underarm sweat (circle a number). 1 2 3 4 5
9. am concerned with wrinkles and visible veins on my hands & would prefer they look more youthful (circle a number). 1 2 3 4 5
10. I am concerned about varicose or "Spider veins" on my legs or body (circle a number). 1 2 3 4 5
11. I would like to have hair on my face, bikini area, underarms or other areas waxed (circle a number). 1 2 3 4 5
12. I am bothered by muscle tightness, tension, or other pain in neck and/or back area (circle a number). 1 2 3 4 5

I am interested in learning about the following procedures or products (please check all that apply):

- ☐ BOTOX Cosmetic™ (Botulinum Toxin Type)
- ☐ Skin Care Advice
- ☐ Skin Care Products
- ☐ Micro-Needling Treatments
- ☐ Removing Submental Fat ("Double Chin")
- ☐ Dermal Injectable Filler
- ☐ Facials or Various Facial Treatments
- ☐ Chemical Peels
- ☐ Waxing, areas: _____
- ☐ Laser Treatments for: _____
- ☐ Eyelash Extensions, Tinting or Perming

If we host an event to inform patients about cosmetic procedures, would you like to attend? ☐ Yes, ☐ No, ☐ Maybe.

If yes, how may we contact you about these events? ☐ Text, ☐ Email, ☐ Either/Both

Signature: _____ Date _____

RJ EDWARDS
AESTHETIC CLINIC

Summary of the HIPAA Privacy Rule

HIPAA: The federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
- File a complaint with your provider or health insurer, or
- File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You also can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule

- Providers and health insurers who are required to follow this law must keep your information private by: Teaching the people who work for them how your information may and may not be used and shared,
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare; your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.