PracticallyPerfect
MEDICAL AESTHETICS

Date:_____

New Client Form

Name (Last/First):_____ DOB:_____ Age:_____

Street Address:_____

City, State, & Zip Code:_____

Phone: Cell:_____ Home: _____ Work:_____

Email address (will not be shared):_____

How do you prefer to be contacted: Cell:_____ Home:_____ Work:_____ Email:_____

Occupation:_____ Employer:_____

Primary Care Physician:_____

Pharmacy:_____ Phone:_____

Who may we thank for referring you?_____

CONSENT TO PHOTOGRAPH: I, the undersigned, do hereby authorize Practically Perfect Aesthetics, Inc. to photograph my treatment areas for my medical record and I agree that the negatives, prints, or digital images may be used for;

Patient Education (office only), _____ Lecture/Demonstration_____ Website (no identifiers)_____

Client Signature_____ Date_____

HIPAA Consent

This form permits *Practically Perfect Aesthetics, Inc.* to use and/or disclose your identifiable health information to include the date and type of treatment you received. Your information will only be shared with the individuals that you list below.

The information will be used or disclosed for the purpose "At the request of the individual".
This authorization HAS NO EXPIRATION DATE.

By signing this authorization, I authorize Practically Perfect Aesthetics, Inc. to use and/or disclose certain protected health information about me to:

1. Name:_____ Relationship:_____
2. Name:_____ Relationship:_____
3. Name:_____ Relationship:_____

Signature: _____ Date:_____