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WELCOME TO THE AESTHETIC SKIN & LASER CENTER!

Thank you for selecting our practice! So that we may best serve you, please fill out this form as accurately as possible and return it to our receptionist. If you have any questions or need assistance, please ask us – we are happy to help. Thank you.

PATIENT INFORMATION:

Name: _____ Email: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Which number do you prefer we use to contact you? _____

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

Social Security Number (for insurance purposes only): _____ Gender: Male: ___ Female: ___

Birthdate: _____ Age: _____

Check appropriate box: Minor Single Married/Domestic Partners Divorced Widowed Separated

Occupation: _____

Patient's Employer: _____

If Student, Name of School/College: _____

Person to contact in case of EMERGENCY: _____ Phone: _____

(Emergency Contact's) Relationship to patient: _____

HOW DID YOU HEAR ABOUT US:

Dr. Barad Internet Newsletter/blog Social Media (FB, LinkedIn, etc.) Ad (gym or _____)

Open House... Other: _____

If referred by a patient, who? Name: _____ Phone: _____



MEDICAL INFORMATION:

Primary Care Physician: _____ Phone #: _____

Have you ever undergone a cosmetic procedure? **YES** **NO**

If yes, what type/s? _____

Were you satisfied? (Please describe what you may have liked/disliked)

Reason for today's visit: (Please also describe your expectations)

On a scale of 1 to 5 how satisfied are you with your life (personal or professional? 5 being the most satisfied).

Additional services that you may be interested in:

X _____ Date: _____

SIGNATURE OF PATIENT, OR IF MINOR, PARENT OR RESPONSIBLE PARTY



Patient Name: _____ Age: _____ Date: _____

Ethnic Background: African-American Caucasian Hispanic Indian Native American Other _____

Which of the following do you consider to be your skin type? (PLEASE CIRCLE ONE)

- I: Highly sensitive, always burns, never tans.
- II: Very sun sensitive, burns easily, tans minimally.
- III: Sun sensitive skin, sometimes burns, slowly tans to light brown.
- IV: Minimally sun sensitive, burns minimally, always tans to moderate brown.
- V: Sun insensitive skin, rarely burns, tans well.
- VI: Sun insensitive, never burns, deeply pigmented.

Past Medical History:

Do you take/use any medications, herbal/ natural supplements or topical treatments on a regular or daily basis?

If yes, please explain: _____

Do you have any allergies to medications, foods, latex, or other substances? If so, please explain.

Do you have a history of any of the following conditions? Please circle.

Syphilis Hepatitis HIV Psychiatric Problems Herpes Smoking Alcohol Other: _____

Do you exercise? ___ YES ___ NO If yes, please describe your usual routine: _____

Please describe your diet: _____

_____ Daily Fluid Intake: _____

Have you had recent exposure to the sun? ___ YES ___ NO If yes, how long ago? _____

How frequently are you in the sun? _____

Do you use tanning beds? ___ YES ___ NO If yes, when was the last time? _____

Do you use self-tanners? ___ YES ___ NO If yes, which one, and when did you last use it? _____

Do you use sunscreen daily? ___ YES ___ NO If yes, what brand: _____

Which of the following describes your skin? Dry Oily Normal/Combination Acne Prone

Have you used any of the following? Please mark all that apply.

Retin-A Accutane Benzoyl Peroxide Retinoids/Retin-A Salicylic Acid Glycolic Acids

Please describe your current skincare routine and products that you use: _____

X _____

Date: _____

SIGNATURE OF PATIENT, OR IF MINOR, PARENT OR RESPONSIBLE PARTY



LEGAL AGE AND DISCLOSURE OF MEDICAL HISTORY

I certify that I am a competent adult of at least 18 years of age. If the patient is not of legal age, the undersigned certifies that I am the patient’s custodial parent or legal guardian and that I have full power and authority to consent to the treatment on behalf of the minor patient. I will disclose a full and accurate personal medical history, including any and all information regarding medical conditions and use of medications, drugs, herbs, vitamins, or other supplements of any kind. **I understand that failure to do so may affect my treatment outcome and increase the likelihood or severity of side effects or complications.**

CONSENT TO TREATMENT

I understand and agree that I am consenting to receive a cosmetic treatment or service. This is strictly a voluntary cosmetic procedure. No treatment or service is necessary or required. The risks and complications associated with treatments or services and various alternatives have been explained to me by the Aesthetic Skin & Laser Center staff. **I freely and voluntarily agree to undergo the treatment or service.** I understand that the Aesthetic Skin & Laser Center services generally consist of a series of treatments and services to achieve maximum benefit and this consent shall apply to all services rendered to me by the Aesthetic Skin & Laser Center, including ongoing or intermittent treatments.

NO GUARANTEE

I UNDERSTAND THAT NO GUARANTEE HAS BEEN GIVEN AS TO THE RESULTS THAT MAY BE OBTAINED BY ANY OF THE SERVICES OR TREATMENTS OFFERED BY THE AESTHETIC SKIN & LASER CENTER. Best efforts will be made to deliver excellent results and it is understood that patient compliance with recommendations is critical for optimal outcomes.

FINANCIAL RESPONSIBILITY FOR TREATMENT (please initial next to each line)

I understand that aesthetic treatments or services are not medically necessary, and are therefore not covered by any insurance or other third party payer program. I understand that I am fully responsible to pay for all of the services rendered to me.

In some instances, a pre-paid package of services may be purchased at a discount off of customary rates. As a condition of receipt of the discounted rate, I acknowledge and agree that packages of pre-paid services and treatments *are non-refundable for any reason.*

I understand that all services, including prepaid services, are non-refundable. I will not be entitled to a refund if I am not satisfied with the results of treatment, on account of a delay in treatment, if I relocate from the area, *or for any other reason whatsoever.*

I understand that if the procedure takes longer than the customary time, the AESTHETIC SKIN & LASER CENTER reserves the right to charge an additional fee for each additional half hour.

PAYMENT INFORMATION

Payment for today will be made by: CASH CHECK VISA/MC/DISCOVER

X _____ Date: _____

SIGNATURE OF PATIENT OR PARENT IF MINOR OR RESPONSIBLE PARTY



SCHEDULING AND CANCELLATION

While ASLC will strive to schedule and provide treatments during ASLC’s normal business hours and at such times as I may reasonably request, ASLC cannot guarantee against delays in treatment due to scheduling conflicts for ASLC personnel, maintenance to medical equipment, or any other foreseen or unforeseen causes.

If you cannot keep your appointment, please cancel as soon as possible. In order to assure our patients the highest level of service, we require a **48-hour cancellation notice**. If such courtesy notice is not given, a **\$50** charge will apply for appointments with the medical aesthetician and **\$100** will apply for appointments with the doctor. All patients who do not give such notice will have to put a deposit toward their next appointment, which is forfeited if the "no show" recurs.

Failure to show for treatments that require an hour or more of staff time or special preparation will be charged at the full value. Failure to show or cancel 48 hours in advance for a treatment that is part of a package will result in forfeiting of that session.

Please plan on arriving about 10 minutes before your scheduled time to allow for unforeseen delays, such as traffic, parking or paperwork. Arriving 15 minutes or more late for an appointment may result in the need to reschedule or shorten your appointment time accordingly.

X _____ **Date:** _____

SIGNATURE OF PATIENT OR PARENT IF MINOR OR RESPONSIBLE PARTY

ACKNOWLEDGEMENT AND CONSENT TO TREATMENT (To be signed after the consult!)

I hereby acknowledge that I have read and understand all of the information presented to me before signing this acknowledgement and consent that the benefits and risks as well as the alternatives to the treatments or services have been fully explained to me and all questions that I might have about the treatments or services have been answered in a satisfactory manner. I hereby give unrestricted informed consent to receive the treatment and services. This acknowledgement and consent shall apply to all services rendered to me by the Aesthetic Skin & Laser Center staff, including ongoing or intermittent treatments.

I accept full financial responsibility for this treatment and all subsequent treatments. I further agree, in the event of non-payment, to bear the cost of collection, including court costs and attorneys’ fees, should this ever be required.

Signed: _____ **Date:** _____

Printed Name: _____