

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home # \_\_\_\_\_ Work# \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact Name and Phone \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Area(s) to be treated today: \_\_\_\_\_

**Past or present Illnesses/Medical Conditions, please list:**

Are you currently under the care of a physician?    Yes    No

Do you have any of the following medical conditions? (please circle all that apply)

Cancer	Diabetes	High blood pressure	Herpes	Frequent cold sores
Arthritis	HIV/AIDS	Keloid scarring	Hepatitis	Skin disease/lesions
Any infection		Seizure disorder	Thyroid imbalance	

Any other medical condition? \_\_\_\_\_

Allergies: \_\_\_\_\_

**Present Medications (Please circle all that apply)**

Accutane    Birth control pill    hormone    Antibiotics    Aspirin    Coumadin

Topical Retin-A

Other: \_\_\_\_\_

Do you have any implants/injectables/permanent make-up? If so, please list: \_\_\_\_\_

Do you have any tattoos? If so, please list location: \_\_\_\_\_

Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_ LMP \_\_\_\_\_

History of keloids/hypertrophic scars: yes \_\_\_\_\_ no \_\_\_\_\_

Tanning history (including direct sun, self tanners, spray tans) Please list and include last date of use:

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Previous Laser Treatment: (specify date/number of treatments/frequency/tissue response/device used, if known):

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Previous Hair Removal History, if applicable:

Wax epilation \_\_\_\_\_ Mechanical epilation (plucking) \_\_\_\_\_ Electrolysis \_\_\_\_\_ Bleaching \_\_\_\_\_  
Shaving \_\_\_\_\_

Frequency/and last use of above modalities:

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Other type treatment: \_\_\_\_\_

Have you ever had a cosmetic peel/cosmetic procedure? Please list

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**FOR STAFF ONLY:**

**Recommendations: Discussion with provider**

- \_\_\_\_\_ 1. Treatment options (testing, brown or black hair responds best, number of treatments).
- \_\_\_\_\_ 2. Client expectations: (understand need for multiple treatments, after care, possible side effects, etc).
- \_\_\_\_\_ 3. Physician consultation (if required in your state) before or after test for a treatment recommendation.
- \_\_\_\_\_ 4. Full treatment schedule process (waiting period in-between treatments, expected results.,
- \_\_\_\_\_ 5. Possible side effects (hyperpigmentation, hypopigmentation, purpura, scarring, textural changes, burns, blistering, pain or discomfort and erythema) and length of time to expect healing if side effects occur.
- \_\_\_\_\_ 6. Specifics of area to be treated. Test small area for tissue response BEFORE full treatment.
- \_\_\_\_\_ 7. Importance of sun exposure avoidance and the use of a broad spectrum zinc oxide or titanium dioxide UVA/B sun block with SPF 30 or higher. during the entire treatment program.
- \_\_\_\_\_ 8. Sensation of the laser/DCD spray and the option for topical anesthesia or other cooling methods.
- \_\_\_\_\_ 9. Benefits of laser treatment (possible long-term hair removal),
- \_\_\_\_\_ 10. Cost of treatment (payment schedule, cost of multiple treatments versus single payment per visit).
- \_\_\_\_\_ 11. Eyewear protection and laser safety measures required for patient and provider. Patients may sense light while wearing proper eye protection.
- \_\_\_\_\_ 12. Importance of post care instructions/procedures.

Photo taken today: YES \_\_\_\_\_ NO \_\_\_\_\_

COMMENTS: \_\_\_\_\_

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I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been addressed to my satisfaction.

Name .....

Date .....

**POINTS**

	0	1	2	3	4	SCORE
What Color are your eyes?	Light blue, grey, green	Blue, grey, green	Blue	Dark Brown	Brownish Black	
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black	
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown	
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None	
<b>Total for Genetic Disposition =</b>						

	0	1	2	3	4	SCORE
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never burns	
To what degree do you turn brown?	Rarely or never	Light color tan	Reasonable tan	Tans very easily	Always turns dark brown	
Do you turn dark brown within several hours of sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face respond to sun exposure?	Very sensitive	Sensitive	Normal	Very resistant	Never had any problem	
<b>Total for Response to Sun Exposure =</b>						

	0	1	2	3	4	SCORE
When did you last expose your face/body to sun (include artificial exposure)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Did you expose the area to be treated to sun?	Never	Seldom	Sometimes	Often	Always	
<b>Total for Tanning Habits =</b>						

**Total for Genetic Disposition =** \_\_\_\_\_

**Total for Response to Sun Exposure =** \_\_\_\_\_

**Total for Tanning Habits =** \_\_\_\_\_

**TOTAL SKIN TYPE SCORE =** \_\_\_\_\_

TOTAL SCORE	FITZPATRICK SKIN TYPE
0-7	I
8-16	II
17-25	III
25-30	IV
OVER 30	V-VI



## **NOTICE OF PRIVACY PRACTICES**

**This notice describes how health information about you as a patient of this practice may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Our practice reserves the right to change this Notice in the future.**

### **Our commitment to your privacy**

**Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:**

### **Use and disclosure of your health information in certain special circumstances**

**The following circumstance may require us to use or disclose your health information:**

- 1. To public health authorities and health oversight agencies that are authorized by law to collect information**
- 2. Lawsuits and similar proceedings in response to a court or administrative order**
- 3. If required to do so by a law enforcement official**
- 4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.**
- 5. If you are a member of U.S. or foreign military services (including veterans) and if required by the appropriate authorities**
- 6. To federal officials for intelligence/national security activities authorized by law**
- 7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official**
- 8. For Workers Compensation and similar programs**

### **Your rights regarding your health information**

- 1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.**
- 2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of our health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree with your request; however, if**

we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have a right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: FIX Wellness Center, 3600 Oceanview Blvd, Suite 1, Glendale, CA, 91208.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept for or by our practice. To request an amendment your request must be made in writing and submitted to: FIX Wellness Center, 3600 Oceanview Blvd, Suite 1, Glendale, CA, 91208.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk reception or download a copy from our website at [www.fixwellnesscenter.com](http://www.fixwellnesscenter.com).
6. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with our practice, contact the Practice Privacy Office at (818) 248-9575. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. You have a right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law.

If you have any questions regarding this Notice or our health information privacy practices, please contact the Practice Privacy Office at (818)248-9575. I hereby acknowledge that I have been presented with a copy of FIX Wellness Center's Notice of Privacy Practices.

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Signature of Patient

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Date

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Printed Name of Patient

If it's not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

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Signature of Provider Representative

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Date

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Title of Provider Representative

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Description of effort/reason needed



## **GENERAL CONSENT FORM**

With all of the options in laser care, today, we are pleased that you have selected the service of Fix wellness Center. We are certain you will find that our standards and personalized patient care rank among the best in the industry. Please review the following information regarding your treatment. Remember that our staff is more than happy to answer any questions that you may have. Finally, it is our pleasure to welcome you to Fix Wellness Center.

## **NOTICE OF CONFIDENTIALITY**

I understand that Fix Wellness Center will retain my treatment records for a full 3 years after treatments cease. During this time, all personnel at Fix Wellness Center including the physicians, nurses and Medical Director will have complete access to my records. However, no third party shall receive copies of my records without my specific written consent. Only under appropriate medical review may any information regarding my treatment be released and studied to further ensure the efficacy and safety values of Fix Wellness Center. I understand that the staff at Fix Wellness Center may ask to photograph the area being treated to document and track the results. Fix Wellness Center will always use the utmost discretion while taking such photographs and will never release them without my full knowledge and expressed written consent.

## **MEDICAL HISTORY DISCLOSURE**

Fix Wellness Center wants to provide me with the utmost level of care. Thus, I am aware of the importance of disclosing my complete, personal medical history. I will notify the staff of Fix Wellness Center of changes in my healthcare as they occur during my treatment process. In addition, I will also inform the staff of Fix Wellness Center of all medication that I currently take, including but not limited to: prescription and over the counter drugs, herbs, supplements, vitamins and birth control pills. I understand that any failure to do so on my part may result in an increase in the likelihood of side effects or complications post treatment.

## **POSSIBLE RISKS AND SIDE EFFECTS**

I am completely aware of and have further questions regarding possible side effects and risks associated with my treatment. I understand that these include but are not limited to: pain, scarring, bruising, swelling, redness, purpura, blistering, hyperpigmentation and hypopigmentation. I understand that treatments are usually sold in packages to achieve maximum results and that a single treatment may not be sufficient to provide the desired effect. Furthermore, I understand that individual results may vary according to the following factors: skin type, area of body being treated, natural hair color, post treatment care, follow-up care and tanning by sun-exposure or self tanning products. I will minimize these risks by adhering to the post treatment care instructions given to me by the staff at Fix Wellness Center.

Initial (                    )

**CONTINUED CONSENT**

I understand that this signed consent form shall remain effective through my continuity of care on behalf of Fix Wellness Center. This is in regard to the treatment that I shall receive today and any future treatments or services rendered to me by Dr. Voskanian and his staff.

\_\_\_\_\_ I consent to the taking of photographs during the course of my laser therapy for healthcare records.

My signature below attests to the fact that I fully understand and accept all of the above information. I have had answered any questions pertaining to such. I certify that I am at least 18 years of age.

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Printed Name

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Signature

Date





3600 OCEAN VIEW BLVD, # 1  
GLENDALE, CA 91208  
818-248-9575

**Cancellation Policy:**

As a courtesy to other guests and our service providers, we ask that you notify us a minimum of 24 hours in advance if you must reschedule or cancel your appointment. No-Shows will be charged a \$50.00 administrative fee. If you have purchased a series (example laser hair removal package) the treatment will be deducted from your package.

Initial: \_\_\_\_\_

**Medical History Disclosure:**

In order to provide you with the best level of care, it is very important that you disclose your complete, personal medical history and any changes that occur during your treatment process including but not limited to: prescription and over the counter drugs, herbs, supplements, vitamins, birth control pills and most importantly any sun exposure or tanning including any tanning creams or mystic tan. By signing below you understand that any failure to do so may result in an increase in the likelihood of side effects or complications post treatment.

Initial: \_\_\_\_\_

**Laser hair removal is only effective for coarse dark hair. Fine facial hair does not respond to laser hair removal and occasionally can get thicker.**

Initial: \_\_\_\_\_

My signature below attests to the fact that I fully understand and accept all of the above information. I have had all my questions pertaining to the above issues answered and I certify that I am at least 18 years of age.

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**3600 Ocean View Blvd, Suite 1  
Glendale, CA 91208**

**Tel: (818)248-9575 Fax: (818) 248-9555**

## PATIENT INSTRUCTIONS FOR LASER HAIR REMOVAL

### PRETREATMENT INSTRUCTIONS

1. Avoid the sun 4-6 weeks before and after treatment.
2. You **MUST** avoid bleaching, plucking or waxing hair for 4-6 weeks prior to treatment. The melanin-containing hair must be present in the follicle as it is the "target" for the laser light.
3. Please inform us if you have had a history of perioral or genital herpes simplex virus.
4. **RECENTLY TANNED SKIN CANNOT BE TREATED! If treated within 2 weeks of active (natural sunlight or tanning booth) tanning, you may develop hypo-pigmentation (white spots) after treatment and this may not clear for 2-3 months or longer.**
5. The use of self-tanning skin products **must** be discontinued one week before treatment. Any residual self-tanner should be removed prior to treatment.
6. The hair in the treatment area should be shaved or trimmed 24 to 48 hours before your visit.

### POSTTREATMENT CARE

1. Immediately after treatment, there should be erythema (redness) and edema (swelling) of each hair follicle in the treatment site, which may last up to 2 hours, or longer. The erythema may last up to 2-3 days. The treated area will feel like a sunburn for a few hours after treatment.
2. You may apply an ice pack to the treated area after treatment to ensure your comfort.
3. A topical soothing skin care product such as aloe vera gel may be applied following treatment if desired.
4. Makeup may be used immediately after the treatment as long as the skin is not irritated.
5. **Avoid sun exposure to reduce the chance of hyperpigmentation (darker pigmentation).**
6. Use a sunblock (SPF 30+) at all times throughout the course of treatment.
7. Avoid picking or scratching the treated skin. **Do not use** any other hair removal treatment products or similar treatments (**waxing, electrolysis or tweezing**) that will disturb the hair follicle in the treatment area for 4-6 weeks after the laser treatment is performed. Shaving is the preferred method.
8. Anywhere from 10-21 days after the treatment, shedding of the treated hair may occur and this appears as new hair growth. This is **NOT** new hair growth. You can clean and remove the hair by washing or wiping the area with a wet cloth or Loofa sponge.
9. After the axillae (underarms) are treated, you may wish to use a powder instead of a deodorant for 24 hours after the treatment to reduce skin irritation.
10. There are no restrictions on bathing except to treat the skin gently, as if you had a sunburn, for the first 24 hours.
11. Return to the office or call for an appointment at the first sign of the return of hair growth. This may be within 4-6 weeks for the upper body and possibly as long as 2-3 months for the lower body. Hair regrowth occurs at different rates on different areas of the body. New hair growth will not occur for **AT LEAST** three weeks after treatment.
12. Call us with any questions or concerns you may have. Call us if you have any unusual symptom such as burning, blistering, or pain.