The Aesthetic & Wellness Center
Restoring your health and beauty
5219 State Rd. 64 East, Bradenton, Fl | 941.749.0741

PATIENT INFORMATION FORM

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: (M / F)
SSN (Required for Weight Loss Program):_____ Birth Date:_____ Age: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Best number to reach you: _____

E-mail appointment reminders: _____Yes _____ No
Text message appointment reminders: _____ Yes ____ No ****Cell # provider:** _____
E-Newsletter & Promotions: _____ Yes _____No
Email: _____
(You will receive a welcome e-mail or text from us to confirm your appointment reminder preference)

Employment Information:
Employer: _____ Occupation:_____
Phone: ( ) _____ ext: _____
In Case of Emergency:
Name: _____ Relationship: _____ Phone: ( )_____

How did you hear about us?

- □ Magazine
- □ Physician Office
- □ Newsletter
- □ Referral by Current Patient
- □ Sign/Location
- □ Seminar
- □ Coupon Book
- □ Gyms
- □ Local Salon/Spa
- □ Radio advertising
- □ Television
- □ Internet Promotion
- □ Facebook
- □ Website
- □ Internet search

Financial Policy:

Please be advised that full payment for all services will be due at the time services are rendered. For your convenience we accept Visa, Master Card, Discover, Debit Card or Cash. We DO NOT accept personal checks.

No Show or Cancelled Appointment Policy:

We do not accept clients without appointments. Appointments that are not cancelled 24 hours prior to appointment time will be billed a $25.00 cancellation fee. Cancellation or no-show fees must be paid prior to making future appointments and are the sole responsibility of the client. Lipotropic injections missed cannot be credited for future injections. Repeat cancelled, or no-show appointments may result in termination from treatment at this practice.

Cancellation Policy

If you purchase an aesthetic treatment package and do not complete the series, your bill will be reconciled at the individual treatment rate and any resulting credit can be applied only to a gift certificate or to additional services or products. In regards to the Weight Loss Program, if you withdraw from the program, you will not be entitled to a refund of any previously paid monies.

My signature on this form confers the authorization for Medical treatment by Inda Mowett, MD and her staff at The Aesthetic & Wellness Center.

Signature: _____ Date: _____

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What procedures are you interested in?

Check all that apply

Treatment sun damaged skin (brown spots)
___ Face
___ Neck
___ Chest
___ Hands
___ Arms/forearms
___ Legs

Removal of fine lines and wrinkles
___ Full face
___ Forehead
___ Crow's feet
___ Lower face
___ Neck
___ Face and neck

Facial veins/Broken Capillaries/Rosacea
___ Full face
___ Mid-face
___ Nose/Cheeks
___ Lower face

Skin Care Services (other)
___ Microdermabrasion
___ Chemical Peels
___ Micro-Needling
___ Skin Rejuvenation
___ Hand Rejuvenation
___Double chin/Jowls/Eye Fat pads
___Aesthetic VIP Membership

Wellness Testing
___ Metabolic Testing & Evaluation
___ Nutritional Testing & Evaluation
___ Food Sensitivities Testing & Evaluation

Medical Fitness
___Private Fitness Session
___Group Training Classes
___Pre-Natal Exercises
___Yoga Classes

Injectable Fillers (Juvederm/Restylane/Radiesse)
___ Lip augmentation
___ Smile lines
___ Marionette's lines
___ Smoker's lines
___ Volume correction-cheeks/mid- face
___ Lower lids/sunken eyes

Pulsed Light Hair Removal
___ Neck
___ Back
___ Chest
___ Abdomen
___ Underarms
___ Forearms
___ Upper arms
___ Beard (male)
___ Bikini Line
___ Full leg
___ Half Leg
___ Upper lip/chin

Botox
___ Frown lines
___ Forehead lines
___ Crow's feet
___ Smoker's lines
___ Nose lines
___ Neck bands/wrinkles

Hormone Replacement Therapy
___ Hormonal imbalance
___ PMS
___ Pre-menopause
___ Menopause
___ Post-menopause
___ Thyroid Disease
___ Low Testosterone

___**Weight Loss Management**
___ **Therapeutic Massage**

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Medical Fitness Initial Evaluation

Please be as detailed as possible when answering the questions below, thank you.

1. Why are you here today? _____
2. What are your fitness and weight loss goals? (Ideal weight? How much time to get there?)_____
3. What programs have you tried in the past to reach your fitness and weight loss goals?_____
4. What has been successful for you in the past? What has been difficult for you?_____
5. What or who is your support system? Does your spouse and/or close friends workout too? _____
6. Are you currently working out? What type of exercise do you enjoy? How long have you been exercising?_____
7. Do you have any painful areas? Have they been evaluated? Do you have any restrictions?_____
8. How many times do you eat out and/or order take out? What is your favorite place to eat?_____
9. Do you drink caffeine, alcohol or smoke? How much? How often?_____
10. How many days a week do you work out at home or a facility? How long? What time of the day? _____
11. How much water do you drink on a daily basis? Other liquids?_____
12. How many hours of sleep do you get on average? Do you have trouble sleeping?_____
13. What are your stress factors in life? Job, Family, Friends, Health?_____

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14. Do you ever feel weak, fatigued, or sluggish? Yes __ No __ Sometimes ___ When?_____

15. How many meals and snacks do you eat each day? Meals _____ Snacks _____

    -Common Breakfast:_____
    -Common Lunch: _____
    -Common Dinner: _____
    -Common Snacks: _____

16. Do you know how many calories you eat in a day? ___Are you taking supplements? Yes _____ No___
    if yes, list supplements _____

17. Do you often experience digestive difficulties? Any known allergies to foods?_____
    _____

18. Proper nutrition can increase the body's ability to enhance physical and mental performance by up to 80%. Do you feel that a structured nutrition and exercise program would benefit you? Yes ____ No ___

19. What type of trainer and workout are you looking for? _____
    _____

20. Have you ever performed resistance training exercises in the past? Yes _____ No_____

21. Do you have injuries (bone or muscle disabilities) that may interfere with exercising? Yes _____ No_____
    If yes, briefly describe_____
    _____

22. On a scale of 1 to 10, how serious are you about achieving your goals?

    Least 1 2 3 4 5 6 7 8 9 10 Most

23. List in order your personal health and fitness objectives.

    a. _____
    b. _____
    c. _____
    d. _____

24. Any additional comments or info that you feel we should know about you? _____
    _____
    _____
    _____
    _____

Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY

Name	Today's Date
Reason for visit	

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?

	Muscle pain/cramps		Weakness		Arm/leg swelling
	Back pain		Fatigue/tired		Balance problems
	Numbness		Fainting		Unsteady gait
	Joint stiffness		Cold intolerance		Decrease muscle mass
	Hip pain		Decreased endurance		Increased body fat
	Knee pain		Decreased Energy		Sleep disturbances
	Ankle pain		Dryer or thinning hair		Irritability
	Neck Pain		Dryer or thinning skin		Sadness
	Shoulder pain		Chest pain		Bleed/ bruise easily
	Foot pain		Palpitations		Frequent headaches
	Spams		Osteopenia		Asthmatic attacks
	Blurred vision		Osteoporosis		Frequent coughing
	Lack of appetite		Within the last month, 3 months, 6 months		
	Weight gain/Loss		How much? 5 lbs., 10 lbs., 15 lbs., 20 lbs. or more		

DO YOU HAVE?

	Anemia		Arthritis/Gout		Heart disease
	Cancer		Diabetes		Kidney disease
	High Blood Pressure		Low Blood Pressure		Vitamin B12 deficiency
	Liver disease		Lung Disease		Hormonal imbalance
	Thyroid problems		Infections (if yes, explain)		

Are you on any food restriction? If yes, explain _____

_____

_____

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List any previous procedures or surgeries and when (date) you had them done:

_____ Non-smoker _____ Former smoker - how long ago did you quit?_____ Years

_____Smoker, how much?_____ Packs per day – How long have you smoked?_____Years

_____Drink alcohol – How much and how often?_____

Allergies:

	No drug allergies		Aspirin		Codeine
	Penicillin		Iodine		Diagnostic dyes
	Sulfa drugs		OTHER – (please list)		

Are you currently using any medications (prescription or non-prescription) and/or nutritional supplements/vitamins? Please list:

Name of Medication/Supplements	dosage	Frequency

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
Print Name Date

_____ _____
Signature Reviewed by/ Date

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Photography consent

I, _____hereby authorize Dr. Inda Mowett or any member of her staff to take before and after picture(s) prior to begin my fitness training and/or, weight loss program I am receiving. These photograph(s) will be used to monitor my progress and postural changes. Also, it may be used for my file and only portions of my body will be placed in photo albums or slide presentations to show the results of my treatments.

_____ _____
Print Name Sign Name

_____
Date

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Patient Consent: Message and/or Appointment Reminders Per HIPAA Regulations

Today's Date _____

Patient Name:_____DOB:_____

May we leave the following types of messages at your home, work, cell phone number, personal email or:

1.	Office appointment reminders/changes	Yes	No
2.	Labs and/or outpatient test results	Yes	No
3.	Payment requirements for upcoming appointments	Yes	No
4.	When authorization, medical records, other info needed	Yes	No
5.	Prescription refill information	Yes	No
6.	Receive office emails to my personal email account	Yes	No
7.	Receive my before and after photos to my personal email account	Yes	No

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Acknowledgement of Receipt of Notice

As required by the privacy regulation, I hereby acknowledge that I have received a current copy of the privacy notice. You can find a copy of HIPPA form at our website wwww.tawcenter.com under office forms tab. I understand that is my responsibility to read through the given information, make any requests and provide documentation that may protect my confidentiality within this practice.

By way of signature, I provide Inda Mowett, MD with my authorization and consent to use and disclose my healthcare information for the purposes of treatment, payment and healthcare described in the privacy policies.

_____

Signature & Date

My healthcare information may be shared with the following persons:_____

_____

Name & relationship to patient _____

No, my records may not be shared _____

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Attendance and Cancellation/No Show Policy

Dear Valued Patient/Client:

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are in effect for recurrent tardiness and missed appointments

- **24 hour advance notice** is required when cancelling an appointment. This allows for someone else to schedule an appointment during that time. If you are unable to give us 24 hours advance notice you will be charged $25 for your missed appointment, including voicemails left with l**ess** than 24hour notice. This amount must be paid prior to your next scheduled appointment or charged to your credit card on file.

- **Payment Method** - Visa, MasterCard, Discover, American Express and cash. Checks are not accepted.

- **No-shows**
  Anyone who either forgets or consciously chooses to miss their scheduled appointment for any reason will be considered a "no-show." They will be charged $25 for their "missed" appointment.

- **Late Arrivals**
  If you arrive late, your session will be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your appointment may to be rescheduled. Regardless of the length of the treatment actually given, **you will be responsible for the payment of the "full" session**. **Please** plan accordingly and be punctual.

- **No Refunds**
  No refunds will be issued for deposits made if cancellation was not received within 24 hours before scheduled appointment. There will be no refunds provided for unused portions of a weight loss program. Medication and lipo injections are also non-refundable and non-transferable

- **Pre-paid cycles**
  Weight loss patients who have pre-paid for a cycle and have to cancel with notice a scheduled appointment will receive credit towards the next month's payment. Unused weeks will be reconciled at the weekly rate

Sincerely,

Inda Mowett, MD

By signing below, I authorize TAWC to charge the account $25 for cancelling or no show for my schedule appointment. I understand that TAWC may continue to charge my account if time after scheduling an appointment I do not notify the office 24 hour prior to my visit. Or cancel my membership in accordance to the terms, rules, regulations and conditions of this agreement. Additionally, I authorize TAWC to charge my credit/debit card on file in lieu of receiving additional services, at my request. You acknowledge receiving and reading a copy of this agreement.

I hereby authorize TAWC to keep swiped credit card information on file and to charge this card if necessary in accordance with the terms of this agreement.

_____ _____
Print Name Date

_____ _____
Signature Date

R. 12/17