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 a 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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PATIENT MEDICAL PROFILE

NAME	TODAY'S DATE
REASON FOR VISIT	OCCUPATION

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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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

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INFORMED CONSENT FOR RESTING METABOLIC TESTING

I, _____ hereby consent to engage voluntarily in the testing of my Resting Metabolic Rate (RMR) at The Aesthetic & Wellness Center.

This test measures the oxygen that the body consumes. Resting metabolic rate (RMR) is the number of calories you burn while you are resting and not engaging in any type of exercises. Because the RMR typically accounts for 60 to 70 percent of a person's total daily energy expenditure, knowing your RMR

The test is performed by breathing through a disposable mouthpiece that is connected to Resting Metabolic Rate equipment. A nose clip is used to assure that all air passes through the mouthpiece.

You will continue to breathe through the mouthpiece for 10 minutes. This test is painless and requires minimal pre-preparation. To the best of our knowledge, there are no known health risks associated with an RMR evaluation.

I have read this form, and I understand the test procedures that I will perform and the attendant risks and discomforts. Knowing these risks and discomforts, and having had an opportunity to ask questions that have been answered to my satisfaction, I consent to participate in this test.

_____ _____

Patient Name Signature

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RESTING METABOLIC TEST INSTRUCTIONS

Before the Test

It is desirable to measure a person's metabolic rate at a true resting level. To ensure one is at rest, we recommend the following preparation:

1. Avoid eating a meal 4 hours before the test.
2. Do not engage in any strenuous exercise the day before the test and avoid physical activity as much as possible on the morning of the test.
3. Dress comfortably in loose fitting clothing.
3. Avoid stimulants such as caffeine or cold medications. Prescriptions medications should be taken according to schedule.

During and after the Test

1. During the test it will be important to get into a comfortable position and relax as much as possible.
2. A nose clip will be placed on your nose.
3. You will be given a mouthpiece to breathe in to. You will be breathing in fresh air from the room, but the gas that you breathe out will go through a tube into the metabolic analyzer to measure your metabolic rate.
4. Make a nice seal with your lips around the mouthpiece to ensure that all the air you exhale will be analyzed.
5. Do not talk unless you are experiencing problems.
6. Relax. After about 10 minutes the device will beep, indicating it is finished.
7. Plan to have a snack or breakfast after the test.

Patient Name _____ Signature _____