



1301 Plantation Island Drive, Suite 401A  
St. Augustine, FL 32080

145 Hilden Road, Suite 123  
Ponte Vedra, FL 32081

(904) 461-6060 phone

(904) 461-6622 fax

Name: \_\_\_\_\_

First

Middle

Last

Address: \_\_\_\_\_

City

State

Zip

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Cellular Carrier: \_\_\_\_\_

Email Address: \_\_\_\_\_

May we email or text you information on discounts and special offers? Y / N

May we **EMAIL** appointment reminders to your email? Y / N

May we **TEXT** appointment reminders to your phone? (Include carrier above) Y / N

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**\*PLEASE FILL OUT ALL OF THE FOLLOWING \***

**Medical History:**

Family Physician- Name & Phone Number:

List any medical conditions for which you are presently being treated or have been treated:

List any surgical history and any complications including dates and anesthesia:

Name: \_\_\_\_\_

First

Middle

Last

(Continued)

Do you have a history of cold sores? Y / N

Have you had cosmetic procedures or surgery (including fillers, Botox, lasers)?

When and what type?

Allergies: (including prescriptions, over-the-counter medications, latex, etc.)

**Medication History:**

List any medications, vitamins, and over-the counter drugs you are presently taking & dosages:

Have you taken any steroid preparations over the past year?

Have you taken any Accutane therapy over the past 18 months?

**Social History:**

Do you smoke or have you smoked in the past? Y / N If so, how much per day? \_\_\_\_\_

If you **quit** smoking, when did you quit? \_\_\_\_\_

Do you drink? Y / N If so, how many per day? \_\_\_\_\_

**Cosmetic History:**

What area(s) of the face are you interested in having cosmetically improved?

Please indicate the products you use (Cleanser, toner, moisturizer, etc.):

Have you ever used any of the following?

- Retina A - When? \_\_\_\_\_ Reaction? \_\_\_\_\_
- Glycolic Acid - When? \_\_\_\_\_ Reaction? \_\_\_\_\_
- Other: \_\_\_\_\_ When? \_\_\_\_\_ Reaction? \_\_\_\_\_



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## ***Financial Policy***

### **PLEASE READ ALL OF THE FOLLOWING:**

#### **Welcome to Avanti Medical Spa, LLC!**

Our goal is to provide you with quality, state-of-the-art patient care in a cost effective manner. In order to maintain that goal we have established the following policies to improve communication regarding appointments, medical records, and your financial responsibility at the time of service or prior to any scheduled appointment. If you have any questions, please feel free to ask a staff member.

**CONSULTATIONS:** Our consultations include a Visia Complexion Analysis, detailed evaluation and treatment plan. Avanti Medical Spa charges \$50 per consultation with the physician, which is collected prior to the consultation. This fee may be applied to any procedure or product purchased the same day as the initial consultation. Consultations with our Aesthetician are complimentary.

**APPOINTMENT RESERVATION FEE:** It is our policy to charge an appointment reservation fee for specific medical spa treatments and services. This fee will be collected at the time of scheduling to reserve your appointment time. This fee will be applied to your services. The fees are as follows:

- Botox, Xeomin or Cosmetic Fillers- \$50 reservation fee
- Fraxel- 20% pre-payment

**MISSED APPOINTMENTS/LATE CANCELLATIONS:** Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to your cosmetic consultations. In the event that you cancel in less than the requested 24 hours, the \$50 reservation fee will be non-refundable. Our office understands that emergencies do arise, but please call our office to discuss this with a staff member.

**REFUNDS:** All Sales are Final and no refunds will be provided under any circumstances. If you elect not to have a pre-paid procedure performed, the remaining balance can be applied to another product or service.

**PATIENT CALLS/MESSAGES:** The practice maintains an automated attendant with voice mail. We make every effort to answer patient calls as they come in, however if the staff member you are trying to reach is not available, please leave a message. **It is not necessary to leave several messages.** Patient calls are handled in order of priority within 48 hours. If you are experiencing an emergency and unable to reach a staff member, please go to the nearest emergency room.

**Care Credit:** If you are interested in setting up a payment plan you can apply for Care Credit. If you are interested in applying for care credit please discuss this with the aesthetician at the time of service.

**Return check fee:** There will a \$50 charge for returned checks. **IF A CHECK IS RETURNED, FUTURE CHECKS WILL NOT BE ACCEPTED.**

**PATIENT DISMISSAL:** Failure to observe these policies, demonstration of unacceptable behavior, or medical non-compliance can result in dismissal from the practice

**Patient Disclaimer:** By signing below, you also acknowledge that the suggested number of treatments, vials or units is only an estimate. To achieve your desired look, you may require more than the original suggested amount.

I have read, acknowledge the above and hereby understand and agree to the financial policies of Avanti Medical Spa, LLC.

Patient Name: \_\_\_\_\_

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



***Acknowledge of Receipt of Privacy Notice for  
Avanti Medical Spa, LLC***

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Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

We are required by law to make available to you a copy of our Notice of Privacy Practices. A copy is available for you at the reception window and you may take this copy with you if desired. Please sign below to acknowledge that a copy of our privacy practices was made available to you.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

You may authorize certain individuals to be involved in your care. This consent for disclosure includes both health and financial as it relates to your care. Below you may list those individuals for which our office is allowed to release your Protected Health Information.

*Individual's Name (Please Print)*

*Relationship to Patient*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Your Signature is Needed for Permission

\_\_\_\_\_  
Date



### Cosmetic Questionnaire

\*for Men & Women\*

Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

We offer a variety of non-invasive skin care options for **Men and Women**.

Please check all concerns that apply in order to help customize the perfect skin care solutions for you.

### What bothers you about your skin?

<input type="checkbox"/> Wrinkles or Fine lines	<input type="checkbox"/> Hormonal Breakouts
<input type="checkbox"/> Expression Lines	<input type="checkbox"/> Large Pores
<input type="checkbox"/> Volume loss- cheeks or lips	<input type="checkbox"/> Acne
<input type="checkbox"/> Sunken Eyes	<input type="checkbox"/> Uneven skin tone/texture
<input type="checkbox"/> Facial resurfacing	<input type="checkbox"/> Dry Skin
<input type="checkbox"/> Freckles or Discoloration	<input type="checkbox"/> Oily Skin
<input type="checkbox"/> Scarring or Stretch Marks	<input type="checkbox"/> Redness
<input type="checkbox"/> Loose or Sagging Skin	<input type="checkbox"/> Short Lashes
<input type="checkbox"/> Aging Hands	<input type="checkbox"/> Weight Loss

1.) Are you currently using any skin care products? Y / N

o If yes, what products are you using? \_\_\_\_\_

▪ What do or don't you like about your products? \_\_\_\_\_

2.) When looking in the mirror, how concerned are you with your appearance?

1                      2                      3                      4                      5

Not Concerned                      Somewhat Concerned                      Very Concerned

3.) Are you interested in learning more about the products and procedures we offer? Y / N

4.) Do you have any friends or family members that may be interested? Y / N

▪ If yes, please provide their contact information and we will contact them!

• Name: \_\_\_\_\_ Phone: \_\_\_\_\_