Rejuv Medical Patient Demographics

First Name: _____ Last Name: _____

Sex (Circle): Male or Female DOB: ____/____/____ Social Security Number: ____-____-____

Email: _____

Cell Phone: _____ Home Phone: _____

Street Address: _____

City: _____

State: _____ Zip Code: _____

Marital Status: _____ Employer: _____

Occupation: _____ Work Phone: _____

Employment Status (Circle): Full-Time Part-Time Disabled Retired Student Not-Employment N/A

Race (Circle): White Black/African American American Indian Asian Other

Ethnicity (Circle): Hispanic/Latino Not Hispanic or Latino Asian Other

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Please Initial The Statements Below:

___ Rejuv Medical cannot guarantee insurance coverage by your insurance provider

___ I certify that the information I am providing is true and correct. I understand and agree that I am ultimately responsible for payment that may not be covered by my insurance.

_____ I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

Signature: _____

(Patient/Responsible Party Signature) (Date)

Rejuv MEDICAL Louisville

Patient Name: _____

The consent to treatment form explains the risks and benefits of the Contour Light treatments. Patients understands the following:

1. Results vary greatly from person to person. No result is guaranteed.
2. Contour Light is a treatment intended to be implemented in conjunction with a modification in diet and lifestyle as part of a complete protocol. The recommended diet and lifestyle is a critical part of the program and are essential in achieving the maximum results.
3. Temporary hyper pigmentation/ hypo pigmentation (changes in skin color) on rare occasion may occur as a result of treatment.
4. Contour Light should not be used by patients with any of the conditions listed below:

Conditions that Prevent Treatment

Patients agrees (by Initialing) that all of the following are true:

_____ I am over the age of 18

_____ I do not have and never had any of the following medical conditions:

- Cancer (active or within 1 Year of remission)
- HIV/ AIDS
- Hepatitis C or D
- Uncontrolled High Blood Pressure

_____ I am not pregnant or breastfeeding

_____ I do not have a pacemaker

Signature:

By signing below, patient agrees that provider listed above may perform the Contour Light procedure for the purpose of body contouring.

Patient understands and accepts the risks listed above and agrees that all information provided on this form is true and correct to the best of the patient's knowledge.

Patient Signature_____ Date_____

DISCLOSURE TO THIRD PARTIES (OPTIONAL)

By signing below, patient agrees to permit provider and third parties authorized by provider to use patients' name, photos and/ or videos in the marketing of the Contour Light system and procedures. Absent a signature, provider will not disclose patient's identity to any third party except as required by law.

Signature _____

Notice of Privacy Practices

Rejuv

Louisville

Acknowledgement of Receipt of Notice of Privacy Practices

The Notices of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Rejuv Medical's health care operations. The Notice of Privacy Practices also describes my rights and Rejuv Medicals' duties with respect to my protected health information. The Notice of Privacy Practices is available from your therapist.

Rejuv Medical reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revises Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient of Personal Representative Date

_____

Description of Personal Representative's Authority

PERSONAL INFORMATION

Name _____ **Date** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone *(Home)* _____ *Mobile* _____

Email _____ **Date of Birth** _____

Age _____ **Height** _____ **Occupation** _____

Who may we thank for referring you to our office?

Friend or Family _____ **Health Care Provider** _____

Online Search _____ **Wellness Class** _____ **Other** _____

MEDICAL HISTORY

Do you or any family member have/had any of the following? Please put an "X" for you, and "F" for family

☐ Depression	☐ Brain fog	☐ Headache
☐ Heart Attack	☐ Hypoglycemia	☐ Neuropathy/nerve problems
☐ Diabetes	☐ Anemia	☐ Poor Sleep
☐ Thyroid Disease	☐ Cancer	☐ Dizziness
☐ Gallbladder Disease	☐ High Blood Pressure	☐ Arthritis
☐ Kidney Disease	☐ Intestine Problems	☐ Weight gain
☐ Stroke	☐ Shortness of Breath	☐ Back Pain
☐ Fatigue	☐ High Cholesterol	☐ Carpal Tunnel

Is there a certain time of day any of these problems are better or worse? _____

Are you taking any medications/supplements? _____ If Yes, please list _____

Are you pregnant? _____ How many children? _____ How many pregnancies? _____

Are you breast feeding? _____

Any known allergies? _____ If Yes, please list _____

Main Concerns:

1. _____ 2. _____

3. _____ 4. _____

How long have you had this/these concerns? _____

What effect does this have on your body functions or quality of life?

What would be different or better without this/these concerns?

☐ Diminished Stress ☐ More Energy ☐ Improved Self-Esteem ☐ Confidence ☐ Sleep

☐ Work ☐ Family ☐ Outlook

How have you addressed weight management in the past?

☐ Medications ☐ Vitamins ☐ Exercise ☐ Diet and Nutrition ☐ Other

How did the previous methods work for you?

What potential barriers do you foresee that would prevent the change you are looking for?

Do you feel it possible to eliminate or prevent these potential barriers?

What outcome would you like to see for this to be a success for you?

Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I am interested in:

Weight loss ☐ ***Inch Loss*** ☐ ***Anti-Aging*** ☐ ***Metabolism Support*** ☐

Long Term Results ☐

Thank you