JENNIFER L. WALDEN, MD, PLLC
COSMETIC PLASTIC SURGEON
WALDEN COSMETIC SURGERY & LASER CENTER
THE MEDSPA AT NW HILLS

Patient Name: _____ **DOB:**_____

Street Address: _____ **City:**_____ **State:**_____ **Zip Code:**_____

Phone Number:_____ **Email:**_____

Occupation:_____ **Referred By:**_____

Emergency Contact: _____ **Phone Number:** _____

Primary Care Physician:_____ **Phone Number:**_____

Preferred Pharmacy: _____ **Phone Number:** _____

Tell Us About Your Skin

*For an effective, personalized treatment, please be as accurate as possible

Skin Type

☐ Normal ☐ Combination ☐ Oily
☐ Dry ☐ Mature ☐ Breakouts
☐ Acne ☐ Sensitive ☐ Rosacea

What skin conditions would you like to improve?

☐ Acne/Acne Scarring ☐ Age Spots
☐ Pustules (inflamed) ☐ Visible Capillaries
☐ Enlarged Pores ☐ Sun Damage
☐ Blackheads/Whiteheads ☐ Fine Lines/Wrinkles
☐ Hyper-pigmentation (brown spots)
Other _____
_____

Have you ever been prescribed Accutane?ⓉTM?

☐ Yes ☐ No
(last date used)_____

Please check if using any of the following

☐ Hydroquinone _____% ☐ Glycolic /Alpha Hydroxy Acid
☐ Topical Vitamin C
☐ Retinoid (Vitamin A derivatives) i.e.Retin-A, Renova, Differin, Tazorac ____%
☐ Other _____
Last used _____

Are you sensitive to any skin care ingredients or cosmetics?

☐ Yes ☐ No
_____
_____

Do you tan indoors, sunbathe or participate in outdoor activities? Please explain :

_____

Have you recently received any of the following?

☐ Facial Date_____
☐ Microneedling Date_____
☐ Chemical Peels Date _____
☐ Dermaplaning Date _____
☐ Laser
IPL Date _____
Resurfacing Date _____
Scar Revision Date _____
Microlaser Peel Date _____
Hair Removal Date _____

Have you ever had any of the following?

☐ Botox Injections Date _____
☐ Filler Injections Date _____
☐ Rhytidectomy (Face Lift) Date _____
☐ Rhinoplasty (Nose) Date _____
☐ Blepharoplasty (Eye lift) Date _____
☐ Skin Cancer Date _____
☐ Other _____ Date _____

What products do you currently use?

☐ Cleanser Brand _____
☐ Toner Brand _____
☐ Eye Cream/Serum Brand _____
☐ Antioxidant Serum(s) Brand _____
☐ Corrective Serum(s) Brand _____
☐ Topical Prescription Brand _____
How often _____
Last use _____
☐ Sunblock Brand _____
☐ Moisturizer Brand _____
☐ Masks/Exfoliators Brand _____
☐ Make-up Brand _____
☐ Other

Do you have any facial implants? ☐ No ☐ Yes

Are you currently undergoing chemotherapy or radiation therapy? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following?

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☐ Anxiety ☐ Cancer ☐ Hemophilia
☐ Depression ☐ Diabetes ☐ Hepatitis.
☐ Migraines ☐ Thyroid ☐ Herpes(HSV1)
☐ Asthma ☐ Epilepsy ☐ HIV
☐ Sinus Problems ☐ Heart Problems
☐ High/Low Blood Pressure ☐ MRSA

For women only……
☐ HRT ☐ Menopause ☐ Pregnant ☐ Birth Control

Do any of the following apply to you?
☐ Smoker ☐ Wear Contacts
☐ Eat Spicy foods ☐ Exercise

How many glasses of water do you consume daily? _____

When exposed to the sun, do you?
☐ Burn easily ☐ Tan Easily
☐ Never Burn ☐ Never Tan

Are you interested in education/specials for the following: (circle those of interest)
☐ Botox ☐ Fillers ☐ Laser
☐Cosmetic Surgery

I confirm that the answers I have given are correct and I have not withheld any information that may be relevant to my treatment.

Signature:_____ Date_____

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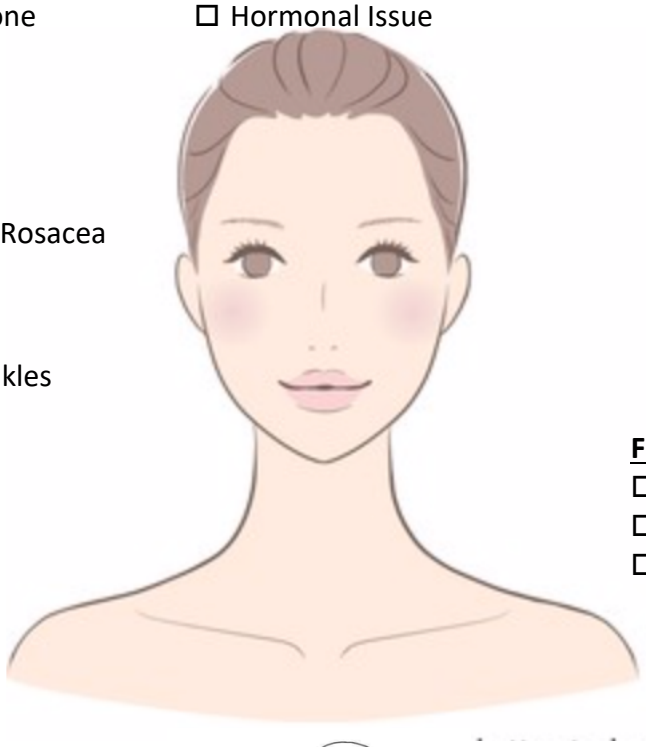
Patient Name: _____ DOB: _____ Date: _____

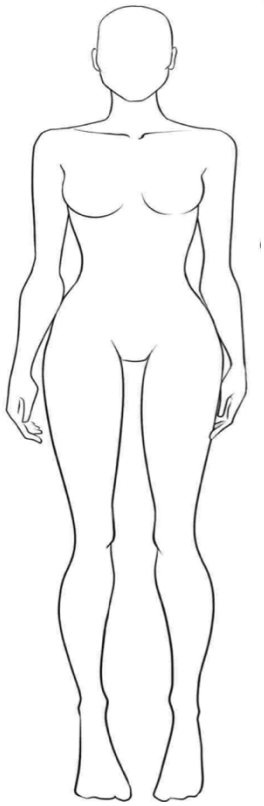
- ☐ Uneven Skin Tone
- ☐ Acne/Scarring
- ☐ Volume Loss
- ☐ Blood Vessels/ Rosacea
- ☐ Sagging Skin
- ☐ Fine Line/ Wrinkles
- ☐ Sun Spots
- ☐ Hormonal Issue
- ☐ Pore Size
- ☐ Hair Loss/ Thinning
- ☐ Dark Circles
- ☐ Crow's Feet
- ☐ Eye Bags
- ☐ Lip Volume or Fullness



Frequent Sweating

- ☐ Underarms
- ☐ Hands
- ☐ Feet

- ☐ Excess Weight
- ☐ Muscle Toning
- ☐ Loose Skin
- ☐ Stretchmarks
- ☐ Loose Skin Above Knees
- ☐ Cellulite
- ☐ Leakage of Urine
- ☐ Dryness/ Painful Intercourse
- ☐ Difficulty Climaxing
- ☐ Enlarged Labia
- ☐ Pelvic Weakness or Changes



Please list any other issues or concerns you would like to discuss today:

_____

_____

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Date: _____

PATIENT HISTORY

NAME

_____

REASON FOR VISIT

_____

AGE HEIGHT WEIGHT MARITAL STATUS SMWD

ALLERGIES: List ANY reactions you have had to medications and describe the symptoms:

_____

_____

MEDICATIONS: List ALL prescription, over the counter, and herbal medications you have taken recently with dosages:

_____

_____

PAST MEDICAL HISTORY: List ANY medical conditions for which you have been treated:

_____

_____

PAST SURGICAL HISTORY: List ALL previous surgery; include complications or abnormal reaction to anesthetics:

_____

_____

SOCIAL HISTORY:

_____

OCCUPATION

_____

EXERCISE HABITS

CIGARETTE SMOKING: ___ YES or ___ NO _____ PACKS PER DAY

ALCOHOL: ___ NONE ___ OCCASIONAL ___ MODERATE ___ EXCESSIVE

_____

DRUG USE

FAMILY HISTORY: Check any of the following that effect first-degree relatives:

___ Anesthetic Problems ___ High Blood Pressure ___ Heart Disease ___ Breast Cancer
___ Diabetes ___ Bleeding Disorders ___ Mental Illness ___ Hereditary Disease ___ Other

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Medical Office Photograph Consent Acknowledgement

(Initials) _____ I acknowledge that I am required to be photographed for my medical record before and after my procedure at *The MedSpa Austin | Northwest Hills by Dr Jennifer Walden*.

(Initials) _____ I allow these images to be used for marketing purposes and social media by Dr. Walden's team, without revealing my identity.

Med Spa Policies

(Initials) _____ All professional services rendered are charged to the patient and due at the time of service. Necessary forms will be completed to help expedite payment for non-cosmetic procedures.

(Initials) _____ Please arrive 15 minutes before your scheduled appointment so that you may fill out any necessary paperwork prior to your service.

(Initials) _____ Your punctuality is greatly appreciated, so that we are able to dedicate the appropriate amount of time to your scheduled treatment/service. Lateness of more than 15 minutes will result in rescheduling your appointment.

(Initials) _____ 24-hour advance notice is required to reschedule or cancel appointments. If we are notified less than 24 hours in advance, a $50.00 fee will be charged.

(Initials) _____ If no notice is given for a missed appointment, a $50.00 fee will be charged and a credit card will need to be placed on file when booking.

(Initials) _____ Our medical spas will no longer be accepting checks for any amount over $500.

(Initials) _____ Gift certificates, packages or series of treatments expire a year from date of purchase.

Refund Policy

(Initials) _____ Deposits made for the purpose of securing a treatment session are non-refundable and non-exchangeable as *The MedSpa Austin | Northwest Hills by Dr Jennifer Walden* sets aside resources for that treatment session. If you have purchased a package or single session, they are non-refundable after your purchase. There are no refunds on services, unless otherwise determined by Management.

(Initials) _____ There are no cash/credit back refunds. We understand that in certain circumstances a refund may be requested if it is determined that a medical condition or contraindication to a type of treatment that has already been purchased exists. If Management determines that compensation is appropriate, the Client will receive a refund or an in-house gift card/credit for an estimated dollar amount to be applied to another service.

Service Providers are not permitted to grant refunds at any time.

Acknowledgement

(Initials) _____ I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures received. I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, nurse or doctor of my current medical or health conditions and to update this history per appointment. I understand that withholding information or providing misinformation may result in contraindications and/or reactions to the skin from treatment(s). The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Patient Signature:_____ **Print Name:** _____	**Date:** _____

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THE MEDSPA - JENNIFER L. WALDEN, MD, PLLC
5656 Bee Caves Road, Building D, Suite 200, Austin, TX 78746 • Tel: 512-328-4100 Fax: 512-328-2132
Effective Date: April 2003

PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO).

To that end, our practice and its physicians and staff will—
1. Adhere to the standards set forth in the Notice of Privacy Practices.
2. Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment life insurance applications, etc. without an authorization from the patient.
3. Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
4. Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its physicians and staff will: Implement reasonable measures to protect the integrity of all PHI maintained about patients.
5. Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
6. Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will: a. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements. b. Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
7. Recognize that although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will— a. Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals. b. Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
8. All patients and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
9. All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____
Signature of Patient or Patient's Personal Representative Date

_____
Print Name of Patient or Patient's Personal Representative Date