Patient's Name ____
Last First Middle

Address ____
Street & Apt # City State Zip

Birthdate____/_____/_____ Age__________ Gender___________

Home Phone ______________________ **Cell Phone**_________________________________

Would you like to receive text messages to confirm your appointments? ________________

E-mail____

Would you like to be added to our Newsletter to learn about specials or events? ___________

Any restrictions for contacting you? ◻ No ◻ Yes Contact Restrictions ________________

Emergency Contact________________________ Relationship to Patient_____________

Home Phone ____________________ Work Phone______________ Cell Phone__________________

If Patient is a Minor:
Parent's Name_______________________________ Birthdate____________________
Home Phone _____________ Cell Phone_______________ Other Phone_____________

Minor Patients
The adult accompanying a minor and the parents (or guardian) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized with a credit card, check, or cash payment at the time of service. As guardian of the minor I authorize treatment unless otherwise noted in writing.

Patient Signature ____ Date _____________________

How did you hear about our practice? ____

What is your reason for coming to see us today? ____________________________________

Patients Ability to Heal:

Does your skin appear fragile, burns easily?	Yes	No
Do you form thick or raised scarring from a cut or burn?	Yes	No
Do you wax or use depilatories on your face?	Yes	No
Do you ever get cold sores?	Yes	No
Are you Pregnant or Nursing?	Yes	No
Have you used Isotretinoin (accutane) in the last 6 months?	Yes	No

Who is your Primary Care Physician?____________________________

Which Pharmacy do you prefer?_______________________________

Areas of Interest:

- Botox/Dysport
- Lip Enhancement
- Skin Resurfacing (Laser, Peel, Etc.)
- Wrinkle Fillers (Injections)
- Skin Care
- Telangectastia (Spider Veins)
- Laser Hair Removal
- Laser Tattoo Removal
- Leg Veins
- Moles
- Skin Tightening
- Medical Weight Loss
- CoolSculpting
- Scar Revision
- Vaginal Rejuvenation (Atrophy, Urinary Incontinence, Tightening)

Allergies:

Allergy	Reaction	

Current Medications:

Medication	Dosage	

Medical Conditions/Surgeries:

Social History:

Exercise:	
Alcohol:	
Tobacco:	

Department of Health and Human Services Privacy Rule under HIPAA (Health Insurance Portability and Accountability Act) Compliance Program

We respect, secure, and protect the privacy of our patients' medical records. When appropriate and necessary, we provide only the minimum necessary to only to those we feel are in need of your health care information and treatment. We support your full access to your personal medical records. We have indirect treatment relationships with laboratories and other health care entities and disclose personal health information for treatment purposes, payment, or health care operations. You may refuse to consent to the use or disclosure of your personal health information in writing. Under this law, we have the right to refuse treatment should you choose not to disclose your personal health information. For any questions, please speak to our HIPAA Compliance Officer.

Patient Signature: ________________________________Date:______________________________

Financial & Office Policy

Cosmetic Services Payment Policy: All cosmetic services provided to you at LUX, LLC are performed strictly for cosmetic purposes. These cosmetic services not are considered medically necessary and are not covered by your insurance company. Your decision to have any cosmetic services rendered indicates that you thoroughly understand and agree with this policy. You will be responsible for payment in full at the conclusion of your visit and fully accept that the charges incurred are out-of-pocket expenses and will not be billed to your health care plan.
Payment Options: We accept all major credit cards and personal checks and cash. Please be aware that we will add a $50.00 charge to your account for returned checks. We also accept Care Credit and Alphaeon Credit. We reserve the right to send all accounts with balances over 60 days old to an outside collection agency. You may be responsible for all reasonable collections and attorney costs incurred.
Pre-Payment: There is a $500 non-refundable deposit required for Cool Sculpting, Laser Resurfacing, and Profractional treatments before the date selected for your treatment can be reserved exclusively for you. This fee is used to cover the booking and scheduling expenses involved with your procedure. This amount will be applied to your total cost. There will be no refunds for services already provided.
Packages and Banked Treatments: Are valid one year from purchase date. Packages and banked treatments are non-transferable, and cannot be shared between patients. If your Provider decides to dis-continue treatment a credit may be given towards other aesthetic services on unused packages. All used services from package will go back to original price and credit left will be available for aesthetic services only.

Cancellation Policy: Our professionals reserve valuable time for you, we request the courtesy of at least a 24-hour notification for canceling or rescheduling appointments. If a patient has missed more than 2 scheduled appointments without at least a 24-hour notification, they will be billed for a $50 No-Show Fee. For missed appointments that are part of a package charge will be made against the package for each missed appointment.

Product Return Policy: Our policy allows you 14 days from the purchase date to exchange an unopened product you may be dissatisfied with. Most skin care product companies will only accept a return or refund on a product if you have had a reaction to the product and complete an "adverse reaction form". Please keep your receipt. Prescription products or compounds cannot be exchanged or returned. ****** LUX~ A Medical Spa does not offer refunds for aesthetic services, weight management programs, and opened retail products.**

Gratuities: As a medical practice, LUX, LLC does not accept gratuity.

Gift Certificates: Spa gift certificates are available for any dollar determination. Certificates are nonrefundable and valid for 12 months from the date of purchase, unless otherwise specified. Gift certificates can be redeemed towards services or merchandise. Lux gift certificates are not accepted at Weniger Plastic Surgery or May River Dermatology and may be redeemed only at LUX, LLC. Place our gift certificates in a safe keeping place. LUX, LLC is not responsible for lost, stolen, damaged, or misplaced certificates.

Disclosure of Financial Interest in May River Dermatology, LLC and Weniger Plastic Surgery:

You are receiving notice because Carmen Traywick, MD and Frederick Weniger, MD may recommend to you procedures or treatments at May River Dermatology, LLC located at 350 Fording Island Road, Suite 100 and Weniger Plastic Surgery located at 350 Fording Island Road, Suite 200. A list of estimated costs of those procedures can be obtained at the front desk at any time. We are required to notify you that Dr. Traywick owns May River Dermatology. Your ongoing care at Lux, LLC is not dependent upon accepting the recommendation for treatment offered at May River Dermatology, LLC. We are required to notify you that Dr. Weniger owns Weniger Plastic Surgery. Your ongoing care at Lux, LLC is not dependent upon accepting the recommendation for treatment or procedures offered at Weniger Plastic Surgery. You have the right to obtain the services offered at May River Dermatology and Weniger Plastic Surgery from any other entity of your choice. Other providers we recommend are:

Dr. Paul Brewer Beaufort Dermatology, P.C. 1096 Ribaut Road, Beaufort, SC 29902	Dr. Sonny Seung-Jun O 966 Houston Northcutt Blvd. Suite H Mount Pleasant, SC 29464

I have read and fully understand the Financial Policy and the Disclosure of Financial Interest.

Signature:______________________________ __________ Date:____________________

Lux, LLC
Email Consent Form

Patient Name: ______________________________ DOB: ________________

RISK OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider. These include, but are not limited to the following risks:

- Email can be circulated, forwarded and stored electronically and on paper
- Email can be immediately broadcast worldwide and be received by unintended recipients
- Email senders can easily misaddress an email
- Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
- Employers and online services have a right to archive and inspect emails transmitted through their systems
- Email can be intercepted, altered, forwarded, or used without authorization or detection
- Email can be used to introduce viruses into computer systems

CONDITIONS FOR THE USE OF EMAIL

Lux, LLC cannot guarantee the security and confidentiality of email communication, and will not be liable for improper use and/or disclosure of confidential information that is not caused by Lux, LLC's intentional misconduct. Patients must consent to the following conditions:

- ***Email is not appropriate for emergency situations***
- All emails containing protected health information (PHI) to or from a patient will be printed out and made part of the patient's record/chart
- Lux, LLC staff may receive and read your email messages
- The patient is responsible for protecting his/her password or other means of access to email
- Lux, LLC is not liable for breaches of confidentiality caused by the patient or any third party
- It is the patient's responsibility to follow up and/or schedule an appointment if warranted
- The patient shall avoid use of his/her employer's computer to send/receive emails to Lux, LLC
- The patient shall inform Lux, LLC in writing of changes in his/her email address
- The patient shall notify Lux, LLC in writing when he/she no longer wants to receive emails from Lux, LLC.

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information Lux, LLC has provided me regarding the risks of using email. I consent to the conditions outlined above, and understand that Lux, LLC may impose other conditions regarding email usage in the future.

Email Address: ____

Patient Signature: ______________________________ Date: ______________

Lux, LLC HIPAA Texting Policy

The new HIPAA texting rules have the aim of controlling who has access to patient health information, how that information is transmitted and received, and how it is consequently protected when it is stored on a portable mobile device. Because third-party service providers and business associates need access to patient health information to efficiently conduct their business, they too are included in the new HIPAA texting guidelines which should ensure the integrity of secure patient data.

Do not send any type of Personal Health information via text messages to your LUX provider. If you wish to text with your LUX Provider you must download "TigerText". The only HIPAA compliant texting app software. This is the only secure messaging platform. Otherwise Lux, LLC employees are not permitted to communicate with you via text messages. Please call the office or give consent for email usage. Lux, LLC is not liable for breaches of confidentiality caused by the patient or any third party.

Patient Name:___________________________________ Date of Birth:_____________________

Patient Signature:____