

Holistic Facial Rejuvenation

Welcome! Enclosed you will find the paperwork you need to fill out before your first facial rejuvenation session. Please note that insurance does NOT pay for facials, as they are a cosmetic procedure. Therefore, you do not need to fill out the section for insurance on the registration form. Nor do you need to fill out anything regarding injuries, etc. unless you are *also* coming for medical care (in which case you also need to fill in the insurance information).

We will review these forms on your first visit. If you have any concerns or questions while filling them out, please feel free to give me a call and I will be happy to address them. If you have a specific sunscreen you use daily, you may want to bring it with you to use after the treatment. otherwise, I will use what I have in the office.

I look forward to meeting you.

Adi Philpott, DO

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PATIENT REGISTRATION

(PLEASE PRINT)

NAME _____ SEX (M) (F)

DATE OF BIRTH _____ AGE _____

MAILING

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____

WORK PHONE _____

SSN _____

EMPLOYED: (YES) (NO) EMPLOYER _____

OCCUPATION _____

STUDENT: (YES) (NO) SCHOOL _____

INJURY: WORK RELATED? (YES) (NO) CAR ACCIDENT? (YES) (NO)

DATE OF INJURY _____

NAME OF PRIMARY CARE PHYSICIAN _____

PHONE NUMBER _____

PRIMARY HEALTH INSURANCE INFORMATION

NAME OF INSURANCE _____

PHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____
ZIP _____

ID NUMBER _____ GROUP ID NUMBER _____

IF THE PATIENT IS NOT THE SUBSCRIBER PLEASE FILL OUT THIS SECTION

NAME OF SUBSCRIBER _____ SEX (M) (F)

DATE OF BIRTH _____

SSN _____ MARITAL STATUS _____

RELATIONSHIP TO PATIENT _____

SECONDARY HEALTH INSURANCE INFORMATION

NAME OF INSURANCE _____ PHONE NUMBER _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
ID NUMBER _____ GROUP ID NUMBER _____

IF THIS IS A WORK RELATED OR AN AUTO ACCIDENT PLEASE FILL OUT THIS SECTION

NAME OF INSURANCE _____ PHONE
NUMBER _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____

ADJUSTERS' NAME _____

CLAIM NUMBER _____

HAS THIS CLAIM BEEN DENIED BY WORKER'S COMPENSATION? (YES) (NO)

ATTORNEY INFORMATION

ATTORNEY NAME _____

PHONE NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

FRONT PAGE (PLEASE FILL OUT BACK PAGE ALSO)

PERSONAL INFORMATION

EMERGENCY CONTACT NAME _____

PHONE NUMBER _____

PHARMACY AND TOWN LOCATED:

HOW DID YOU HEAR ABOUT DR. PHILPOTT? _____

MARITAL STATUS _____ HEIGHT: _____ feet _____ inches WEIGHT: _____ pounds

RACE (for blood work reference): Asian African American Caucasian Hispanic Native American Jewish
Other _____

By signing below you will be indicating that to the best of your knowledge, the services you are requesting will be covered by your insurance plan unless previously discussed. We request that you pay any applicable co-payments or deductible amounts before you leave the office and we will submit the proper claim forms to your insurance plan. If coverage is denied for any reason you will be held responsible for the balance of the bill. *I understand that if I do not have insurance the entire balance is due at the time services are provided.*

I hereby authorize Dr. Adi Philpott to receive payment directly from any insurance company, adjuster, or attorney for my care. This assignment is valid until all balances due are paid in full.

I hereby authorize Dr. Adi Philpott to release any and all information regarding my treatment, diagnostic, or patient information in my medical file to my insurance company(s), attorney, referring doctor, primary care physician, or adjuster, unless notified by me in writing.

I give permission for Dr. Philpott or her staff to leave messages on my answering machine, or with family members, regarding appointments, referrals, or requests that a return phone call is needed.

Signature _____ Print Name _____ Date _____

Physician - Patient Services Agreement
Notice of Dr. Philpott's Policies and Practices to Protect the Privacy of Your Health Information

* I have read or received a copy of the above Notices, Policies, and Practices and agree to the terms and conditions of each. I also understand my rights under each agreement. The above describes how medical information about me may be used and disclosed and how I can get access to this information. *

Patient Name Printed _____ Signature _____

Date _____

(*Note – please ask to read this in the office if you want to – sign this section AFTER you have read it)

BACK PAGE (PLEASE FILL OUT FRONT PAGE ALSO)

Holistic Facial Rejuvenation Intake Form

Adi Philpott, DO

Name _____

What are your major facial concerns?

What are you hoping to accomplish with Facial Rejuvenation?

Have you ever received facial acupuncture treatments? _____

Have you ever received facial non-needle acupuncture treatments? _____

Have you ever received any type of acupuncture or non-needle acupuncture? _____

For? _____

Skin Type: Normal _____ Dry _____ Combination _____ Oily _____ Sensitive _____

Do you: Burn easily? _____ Burn, then tan a little? _____ Burn then tan? _____

Tan easily? _____ Tan readily, rarely burn? _____ Tan, never burn? _____

Skin conditions: Rosecea _____ Acne _____ Eczema _____ Skin Cancer _____

Skin rashes _____ Skin allergies _____ Easy Bruising _____ Itching _____

Are you pregnant? _____ Planning on becoming pregnant soon? _____

Do you have any facial fillers (Restylene, Juvaderm, collagen, etc.)? _____

Do you have (dental) braces? _____

Do you have: A pacemaker _____ Epilepsy /seizures _____ Migraines _____

Frequent headaches _____ Herpes (oral)/cold sores _____

Diabetes _____ High blood pressure _____

Have you ever had any type of cancer? _____ If so, what?

Medications and supplements (*any blood thinners or*

aspirin?) _____

Allergies to drugs, food, *skin care products* or other?

Do you have a regular exercise program and if so what type?

Do you drink alcoholic beverages? _____ How often? _____

Do you drink 6-8 glasses of water a day? _____

Are you a smoker or have you ever been a smoker? _____

How many packs per day? _____ For how many years? _____

How much sun exposure do you get in a week?

Are you currently under a physician's care? _____

If so, please explain condition _____

Any additional health conditions? _____

Emergency Contact Name _____ Phone _____

Signature _____

Date _____ Referred by _____

Consent for Facial Rejuvenation Treatments

Holistic Facial Rejuvenation using ELR™ is NOT for anyone with the following:

Epilepsy /seizures, a pacemaker, pregnant or planning on becoming pregnant soon

Cancer of the brain or skin of the face or neck

Current cold sore or facial herpes outbreak (if no outbreak at the time, no problem)

I, _____, agree that I have none of the above, and consent to undergo non-needle electric current facial “acupuncture” rejuvenation treatments, knowing that there are no guaranteed results.

I acknowledge that I have been advised that using electrotherapeutic and cosmetic procedure could result in redness, allergic reaction to products and *rarely*: bruising, pain, bleeding or other symptoms.

While ELR™ will generally improve rosecea and acne, it there is the slight possibility it could make them worse.

I completely understand and accept the above and agree to undergo these treatments.

Patient signature _____

Print name _____ Date _____

Patient Instructions for Holistic Facial Rejuvenation

Before the treatment:

Come well hydrated – this is important to help the current flow through your cells. Drinking 8-16 oz of water with a packet of Emergen-C (the fizzy vitamin C and mineral drink) added to it before coming for each treatment will be beneficial. It is a quick way to get more minerals into you, which also help to conduct current. (Some Hannaford's and probably most health food stores carry it). Be sure to leave enough time to use the restroom before you lie on the table for an hour! *Extra* water the *few days* before is good if you don't tend to drink a lot of water normally.

A *gentle* exfoliation the night before or morning of treatment really helps products absorb and is an excellent idea

No makeup, but you can remove it once you get to the office if need be (come a little early).

After the treatment:

Expect that you may look a little pink – this is due to the increased circulation

Again, drink lots of water. As this treatment affects the entire body, including detoxifying, it is beneficial to flush yourself out.

Ideal results will be seen if the treatments are given fairly close together – 2 times per week. Expect the results to be longer lasting starting around treatments number 3-5, with more dramatic results after about 10 treatments.

People with a lot of sun damage, smokers, or poor health may need more – up to 20 for - more lasting results.

Remember that your face is a reflection of your health, Good diet, exercise and home skin care are an important part of maintaining your treatment results.

This treatment may make your skin more sensitive to sunlight. *Sunscreen is extra important during this time.*

(Keep this sheet to refer to)