ALCHEMĒ REBELLIOUS HEALTH FOR VIBRANT LIVING

HEALTH HISTORY SUMMARY
CONFIDENTIAL

Patient Name____
Last First Middle Initial

Preferred Name (If Applicable): ______________________________

Address ____

Birth Date______/_______/______

City ________________________State __________ Zip __________

Phone: ____

Email: ____

Emergency Contact:

Name ________________________ Relationship ________________

Home Phone ____________________ Work Phone ________________

Would you like to receive our newsletter? ☐ Yes ☐ No

How did you hear about us:
☐ Internet ☐ Friend or Family ________________________(name)

☐ Ad ☐ Community Event ______________________________

☐ Other: ____

2308 Kettner Blvd Suite C
San Diego, CA 92101
p: 619.501.6523 / f: 619.330.1887
info@alchemehealth.com
www.alchemehealth.com

MEDICAL HISTORY

Please check ALL that apply, both past and present:

- ☐ Acne
- ☐ Addison's Disease
- ☐ Adrenal Fatigue
- ☐ Arthritis
- ☐ Allergies/Hay Fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's Disease
- ☐ Autoimmune Disease
- ☐ Bleeding Tendency
- ☐ Blood Clots
- ☐ Blood Pressure Elevation
- ☐ Blood Transfusions
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chest Pain
- ☐ Cholesterol, Elevated
- ☐ Chronic Fatigue
- ☐ Circulatory Problems
- ☐ Colitis
- ☐ Conn's Syndrome/Disease
- ☐ Cushing' Syndrome/Disease
- ☐ Dental Problem
- ☐ Depression
- ☐ Diabetes Insipidus
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Diverticular Disease
- ☐ Drug Addiction
- ☐ Ears, Eyes, Nose Throat Problems
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Environmental Sensitivities
- ☐ Epilepsy
- ☐ Estrogen-Dependent Tumor
- ☐ Excessive Water Retention
- ☐ Fibromyalgia
- ☐ Food Intolerance
- ☐ GERD
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Grave's Disease
- ☐ Hashimoto's Thyroiditis
- ☐ Headache
- ☐ Heart Disease
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Infection, Chronic
- ☐ Inflammatory Bowel Disease (IBD)
- ☐ Irritable Bowel Syndrome
- ☐ Irregular Heart Beat
- ☐ Kidney or Bladder Disease
- ☐ Liver or Gallbladder Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Mental Illness
- ☐ Migraines
- ☐ Neurological Problems
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pituitary Tumor
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Scleroderma
- ☐ Seasonal Affective Disorder
- ☐ Sinus Problems
- ☐ Skin Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers

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☐ Urinary Tract Infection
☐ Varicose Veins

MEDICAL (MEN)

☐ Benign Prostatic Hyperplasia (BPH)
☐ Decreased Sex Drive
☐ Prostate Cancer
☐ Testicular Cancer

MEDICAL (WOMEN)

☐ Breast Cancer
☐ Cervical Cancer
☐ Ovarian Cancer
☐ Decreased Sex Drive
☐ Endometriosis
☐ Fibrocystic Breasts
☐ Fibroids
☐ Infertility
☐ Menopause, Natural
☐ Menopause, Surgical
☐ Menstrual Irregularities
☐ Ovarian Cyst(s)
☐ Pelvic Inflammatory Disease
☐ Pregnant
☐ Breastfeeding
☐ Recent Miscarriage

List all medications or supplements you are currently taking on a regular or somewhat regular basis, including over the counter drugs:

List any known allergies:

Smoking Status: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoker

Alcoholic Beverages Per Week: ____

Is there any possibility that you may be pregnant at this time: ☐ Yes ☐ No

AESTHETIC ADDENDUM
CONFIDENTIAL

MEDICAL HISTORY
Please check ALL that apply, both past and present:

☐ Chronic skin condition
☐ Photosensitivity
☐ Laser skin resurfacing
☐ Keloid or hypertrophic scar
☐ Botox injection
☐ Tetracycline use for acne
☐ Recent waxing or plucking
☐ Recent sunburn or tan including tanning bed
☐ Skin cancer
☐ Herpes simplex or cold sores
☐ Chemical peel
☐ Accutane use for acne
☐ Pigmentation disorder
☐ Injection of collagen or other dermal filler
☐ Electrolysis or threading

Do you or your family have a history of atypical moles, vitiligo, developing keloids, melanoma or other skin cancer? ☐ Yes ☐ No
If yes, please explain: ____

When exposed to the sun, do you usually:
☐ Always burn, never tan
☐ Tan after initial burn
☐ Rarely burn, tan darkly easily
☐ Burn easily, tan poorly
☐ Burn minimally, tan easily
☐ Never burn, always tan darkly

Do you use sunscreen regularly? ☐ Yes ☐ No
Do you use artificial or "sunless" tanning products? ☐ Yes ☐ No

List any special skin care products you use:

Please list all surgeries (including plastic surgery and wisdom teeth removal) along with the date of the surgery:

Have you or anyone in your family ever had or have a history of unusual reactions or problems with local anesthesia (i.e. Novocaine), topical anesthesia, or general anesthesia? ☐ Yes ☐ No
If yes, please explain: ____

ALCHEMĒ REBELLIOUS HEALTH FOR VIBRANT LIVING

OFFICE POLICIES AND PROCEDURES

APPOINTMENTS:

- Appointments can be scheduled by telephone at 619.501.6523 or online.
- Payment is due at the time of your consultation.
- A credit card is required to hold your initial appointment.

OFFICE CONSULTATIONS:

- Our office is wheelchair accessible. There is 2-hour metered parking nearby as well as valet parking located between the Crack Shack and Juniper and Ivy. Patients spending $125 and over will receive a credit for valet parking.

CANCELLATIONS AND NO-SHOWS:

- Patients who cancel their aesthetic or medical consultation appointment less than 24-hours prior to their scheduled appointment time will be charged 50% of their consultation fee.
- Patients who do not cancel their aesthetic or medical consultation appointment and do not show up will be charged the full consultation fee. Please understand that a missed appointment could have gone to another patient.

QUESTIONS AND FOLLOW-UP:

- Questions regarding your care may be sent via phone or email to our patient care coordinator. Our phone number is 619.501.6523 and our email is patientcare@alchemehealth.com. Email is a not a HIPPA-compliant form of communication and is not designed for urgent concerns.

DISPENSARY:

- Unopened products purchased from our office's dispensary may be returned within 30 days of purchase. Opened products are non-refundable. Probiotics are non-returnable items.

INSURANCE:

- We currently do not accept any insurance plan or bill insurance on your behalf. We can supply you with a "superbill" or medical receipt that you can submit to your carrier for reimbursement. We make no guarantee of payment or reimbursement. Please request a superbill at the time of your appointment.

ACCEPTANCE OF POLICIES AND PROCEDURES

By completing the following you agree to the policies and procedures detailed above.

Name:____

Signature:____

Date:____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information may be used and disclosed and how you can get access to this information. Please review this notice carefully.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are com1nitted to protecting it. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. Before we make an important change in our privacy practices we will change this notice and make the new notice available upon request.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep including information previously created or received before the changes occurred.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed, however we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

- FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

- FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I, ____, acknowledge that Alcheme Health has provided me a written copy of its Notice of Privacy Practices for Protected Health Information.

Name:____

Signature:____

Date:____

ALCHEMĒ REBELLIOUS HEALTH FOR VIBRANT LIVING

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/VIDEOTAPES

Cosmetic dermatology is a visually oriented specialty. As such, it is necessary that medical photographs be taken before, during, and after a cosmetic procedure or treatment. This allows for you to see the before and after effects of the procedure. Photographs are required only for the body part in question and often these images are so close up that identification of the person is not possible. Consent is required to take such images.

Additionally, patients may consent to release these medical photographs/slides, videotapes for a stated purpose such as for use in instructional, educational, or promotional materials. These materials are very important to insure continued understanding of the treatments is available to all patients. Please carefully read the information contained in both sections below, and provide your consent where applicable.

CONSENT TO TAKE PHOTOGRAPHS/VIDEOTAPES

I hearby authorize ALCHEMĒ staff to take pre-procedural, procedural, and post-procedural photographs and/or videotapes. I consent to the use of these images for the purpose of pre-procedural planning and post-procedural evaluation by ALCHEMĒ staff, and I understand that they shall be made a part of my medical record.

Patient Signature:____ Date: _______________

Print Name: ____

Parent or Guardian Signature (if applicable): ____

CONSENT FOR RELEASE OF PHOTOGRAPHS/VIDEOTAPES

I hearby authorize ALCHEMĒ staff to use pre-procedural, procedural and post-procedural photographs and/or videotapes for professional medical or promotional purposes as deemed appropriate by them. I understand I will not be identified by name at any time. Unless necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my face recognizable. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images. The permission may be ALCHEMĒ Health.

Patient Signature:____ Date: _______________

Print Name: ____

Parent or Guardian Signature (if applicable): ____

INTENSE PULSED LIGHT (IPL) INFORMED CONSENT

INTRODUCTION

The Versa IPL Treatments is a new, proven, high-tech skin care procedure. Published studies indicate that Versa IPL Treatments can significantly improve the appearance of fine lines, wrinkles, pore size, textural irregularities, and vascular and pigmentation blemishes in over 80% of cases, with clients reporting a noticeable improvement in the cosmetic appearance of their skin during and at the completion of their program.

Versa IPL treatment consists of directing Intense Pulsed Light (IPL) energy at the skin. The energy passes through the outer surface of the skin, called the epidermis and penetrates into the lower layer of the skin called the dermis. Once in the dermis, the IPL stimulates a cell called a fibroblast to produce your own new collagen. Over several treatments, this new collagen smooths and softens the appearance of your wrinkles, pore size and textural irregularities. Using special filters to control the wavelength of pulsed light, sun-damaged skin with pigmentation abnormalities and vascular blemishes such as spider veins and rosacea can be lightened and improved.

Following Versa IPL treatments, there may be a minor degree of redness and puffiness to the skin, along with some tingling discomfort that usually disappears within 1 hour to 2 days. You may apply makeup immediately and return to your regular daily activities with no “downtime.” A comprehensive skin care program will be recommended to you to use in conjunction with your Versa IPL treatments. It is highly recommended you discuss a maintenance program and begin a home skin care program to prevent potential complications, optimize and maintain the cosmetic improvements you obtain with your Versa IPL treatments.

POTENTIAL BENEIFTS OF VERSA IPL TREATMENTS

The most obvious potential benefits are an improvement in the appearance of wrinkles, pore size, textural irregularities, acne scarring, vascular and pigmentation blemishes of aging or sun-damaged skin.

RISKS ASSOCIATED WITH VERSA IPL TREATMENTS

Although the vast majority of clients receiving Versa IPL treatment never experience any of these complications, you should discuss each of them with a treatment professional to ensure you fully understand the alternatives, risks, potential complications and average outcomes of Versa IPL treatments.

Patient Initials: __________
Date: ____________

- Discomfort: The Versa IPL treatments are very well tolerated office treatments. Client comfort is optimized with the use of topical anesthetic cream and cooling. With these treatments you may experience a minor and tolerable degree of burning and/or tingling discomfort with each treatment.

- Skin Wound: It is exceedingly rare for Versa IPL treatments to cause a blister or skin wound. This is more of a risk in darker or tanned skin types. If a blister or skin wound develops it may take 5 to 10 days to heal, and, in extremely rare instances, may leave a noticeable whitening or darkening of the skin or, even more rarely, a scar. Blisters or skin wounds are much more common if you do not follow the recommended avoidance of sunlight, self tanners, UV light, and florescent light exposure.

- Scarring: Scarring occurs in less than .1% of cases. If you have developed a wound and a scar, the scar may end up being flat and white, large and red, or extend beyond the margins of the injury (keloid). Subsequent treatment or surgery may be required to improve the appearance of the scar. The scar may be permanent. Not following pre- and post-treatment instructions may increase the likelihood of a skin wound or scar.

- Pigment Change: With the IPL energy used in Versa IPL treatments, there is a small risk (<1%) of temporary hyperpigmentation (increased pigment or brown discoloration) or hypopigmentation (whitening of the skin). Usually these pigment effects are temporary and resolve over several weeks or months. Permanent hyperpigmentation or hypopigmentation is very rare. The majority of Versa IPL clients will receive skin care products. The medical skin care products are important to obtain optimal results.

- Tanning: It is essential that you <u>not</u> tan your skin or use tanning creams prior to Versa IPL treatments as the pigment in your skin will absorb some of the IPL energy and this will increase your risk of pigment change or skin wound. You <u>should not have Versa IPL treatments if you have tanned skin</u> until the tan has faded appreciably (at least 6 weeks) and avoid tanning for 2 weeks afterwards. If you are using artificial tanning creams, allow these to fade for 2-3 weeks prior to beginning treatment.

- Bruising: It is exceedingly uncommon to have any skin bruising following treatment. If bruising occurs, make up can be used to cover it immediately and it will usually resolve in 8 to 10 days. As the bruising fades, there may be a rust-brown discoloration of the skin that may take special creams to resolve.

- Infection: Because Versa IPL treatments involve no actual cutting, surgery or skin penetration, infection is exceedingly rare.

- Excessive Redness and Swelling: Rarely, a minor degree of redness and/or puffiness of the skin may follow treatment and usually lasts 1-2 hours and is concealed with make-up. This may persist, in rare instances, for 1-2 days. Versa IPL treatments will leave your skin photosensitized for 48 hours after each treatment and you must avoid light. Failure to do so will result in significant redness and swelling that may be quite disfiguring and may increase the rare risk of complication, such as blisters, scarring and pigmentation changes.

- Fragile Skin: The skin overlying the treatment area may become fragile. Although uncommon, the fragile skin can become reddened and the outer layer may peel off, much

like a blister. This usually settles in 8 to 10 days. Fragile skin or blisters may be more common after IPL if IPL post-care instructions are not followed. If you are subject to cold sores, please notify your treatment professional as cold sore eruptions can be common with Versa IPL treatments, you may need to go on an antiviral medication during your treatment.

- Accutane: Accutane must be stopped 3 months prior to treatment.
- Pregnancy: While there are no known adverse reactions that may affect a fetus, we do not recommend proceeding with treatment if you are pregnant.

ALTERNATIVES TO THE VERSA IPL

- Diode Laser
- Ultherapy

HEALTH INSURANCE

Most health insurance companies exclude coverage for cosmetic procedures such as the Versa IPL. Health-related complications that may arise from such treatment may not be covered by all insurance plans. Please carefully review your health insurance subscriber-information pamphlet if you have a private insurance carrier.

FINANCIAL RESPONSIBILITIES

You will likely be responsible for all payments related to the treatment. Additional costs may occur should complications develop from treatment. There are no refunds once a treatment has been performed.

DISCLAIMER

What our ALCHEMĒ staff members have discussed with you and has been included in this booklet are the material risks both common and uncommon that ALCHEMĒ physicians feel a reasonable person would want to know, understand, and consider in trying to decide if the proposed treatment of a condition is something they would like to proceed with.

However, this handout should not be considered to be all-inclusive in defining other methods of care and risk encountered. ALCHEMĒ staff may provide you with additional or different information that is based on all the facts of your particular case and the current state of medical knowledge.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information contained on this and all preceding pages carefully and have all of your questions answered by ALCHEMĒ staff before signing the consent on the last page.

Patient Initials: __________
Date: ____________

CONSENT FOR PROCEDURE AND/OR TREATMENT

I have received the following information and informed consent for the Versa Intense Pulsed Light

1. I hearby authorize ALCHEMĒ staff to perform the Versa Intense Pulsed Light treatment.

2. I recognize that during the course of the procedure/treatment unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and/or assistants or designees to perform such other procedures that are in the exercise of his or her professional judgement necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.

3. I consent to the administration of such topical anesthesia considered necessary or advisable.

4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

5. I understand that the signature of a witness (if a non-physician or registered nurse) on this document indicates only that the signing of my name has been observed and not that the witness has necessarily provided information regarding the procedure.

6. I consent to and understand that:
   a. The above treatment or procedure may be undertaken
   b. There may be alternative procedures or methods of treatment
   c. There are risks to the procedure/treatment proposed
   d. Any questions I may have asked have been answered to my satisfaction

I CONSENT TO THE PROCEDURE AND/OR TREATMENT AND THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLINATION OF RISKS AND BENEFITS.

Patient or Legal Guardian:____

Print Name: ____

Date: ____

Witness: ____

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