

**ADVANCE COSMETIC AND LASER CENTER**

Dr. Tim Roham

629 Camino De Los Mares

Suite 103, San Clemente Ca. 92673

**PATIENT HISTORY**

Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Date of Birth \_\_\_\_\_

Telephone Home \_\_\_\_\_ Cell \_\_\_\_\_

Work \_\_\_\_\_

What number is best to leave a message \_\_\_\_\_

Family Doctors Name and Address \_\_\_\_\_

Contact Name and Telephone (In case of Emergency) \_\_\_\_\_

**Allergies or Sensitivity to medications or materials** \_\_\_\_\_

If yes describe your reaction \_\_\_\_\_

How did you hear about the practice? \_\_\_\_\_

Please put a check mark next to the procedures about which you would like to receive more information:

Facial Therapies:

- Acne
- Botox
- Fillers/Restore Volume
- Wrinkles and Sun Damage
- Skin Tightening
- Pore size/ Texture
- Eye Lid Lift

Laser Treatments:

- Tattoo Removal
- Hair Removal
- Brown Spots
- Skin Tightening
- Spider Veins/ Leg veins
- Broken Capillaries/Redness
- Shaving Bumps/ Ingrown Hair

Body Treatments:

- Liposuction
- Cellulite
- Breast Augmentation
- Tummy Tuck

**GENERAL MEDICAL QUESTIONNAIRE**

Height: \_\_\_\_\_ Weight \_\_\_\_\_

Do you enjoy good health? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you presently under the care of a doctor? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you ever been to hospital for surgery? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, when & why? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how many per day? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how much per week? \_\_\_\_\_

Do you regularly take aspirin?  Yes  No  
 When was the last time you took aspirin or anti-inflammatory medicine? \_\_\_\_\_  
 Do you have a tendency to scar easily (keloid)?  Yes  No  
 Have you ever had blisters around the mouth (cold sores) (Herpes)?  Yes  No

**DO YOU SUFFER FROM ANY OF THE FOLLOWING MEDICAL CONDITIONS**

|                      |  |                           |  |
|----------------------|--|---------------------------|--|
| Heart Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Problems      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Disease              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Aids or HIV positive | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorder    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bruise Easily        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dark Stains after Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Women Only**

Do you have children?  Yes  No  
 If yes how many? \_\_\_\_\_  
 Are you on Hormone Replacement Therapy?  Yes  No  
 Are you taking Birth Control Pills?  Yes  No

**List all medication or herbal supplements that you are currently taking:**

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A **50.00 charge** will be applied to appointments not canceled **24 hr. in advance**  
 There will be **No refunds** on packages, remaining monies maybe used as a  
 credit in patients favor and may be used for any procedure.

I have answered the questionnaire to the best of my ability

Signed: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Under Health Information Portability and Accountability Act (HIPAA)  
 "Individually identifiable health information" may be disclosed only with written  
 permission to anyone other than the patient. All discussions about patient medical  
 conditions must be kept in a private setting. All medical records are to be accessed on an  
 as needed basis.

Please sign below to indicate you have read and agree to the above policies.

Print Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

Physician \_\_\_\_\_

# HIPAA Notice of Privacy Practices

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## Advance Laser & Cosmetics

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### Uses and Disclosures of Protected Health Information

#### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use require by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physical therapist or rehabilitation therapist that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for physical therapy may require that your relevant protected health information be disclosed to the health plan to obtain approval for therapy.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk were you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Require By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when require by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken and action in reliance on the use or disclosure indicated in the authorization.

### **Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

**You have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us, AAAHC, LA County Health Services or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer or Administrator. **We will not retaliate against you for filing a complaint.**

**U.S. Dept. of Health & Human Services, 200 Independence Ave, Washington, D.C. 20201 (877) 696-6775**  
**Los Angeles County Health Services, 5555 Ferguson, Ste 320 Commerce, CA 90022 (323) 890-8500**  
**AAAHC, 5250 Old Orchard Road, Suite 200, Skokie, IL 60077 (847) 853-6060**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please as to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Advance Laser & Cosmetics

## Financial Agreement for Cosmetic Procedures

I, \_\_\_\_\_ agree that any cosmetic procedure/treatment preformed by Dr. Roham or Advance Laser & Cosmetic Staff are my financial responsibility.

I ALSO UNDERSTAND AND AGREE TO THE FOLLOWING:

I am financially responsible for the full cost of any procedure or treatments preformed by Dr. Roham.

I understand that the fees, deposits and/or payments collected are for the procedure/treatment I received today, with the exception of pre-paid packages.

I understand that future follow up care and/or subsequent treatment/procedures will be paid individually.

I understand that any Pre-Paid Treatment, Fees, Deposits and/or Payments for packages are also NON-REFUNDABLE and NON-Transferable.

I understand that there are NO CREDIT CARD CHARGE BACKS/DISPUTES. Any financial dispute will be resolved directly between me and Dr. Roham/Advance Laser & Cosmetics.

I also understand that all deposits or payments I make to Advance Laser & Cosmetics are NON-REFUNDABLE.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

*ADVANCE COLMETHE AND LASER CENTER*

*Dr. Tim Roham*

*629 Camino De Los Mares*

*Suite 103, San Clemente Ca. 92673*

**RELEASE FOR ALL PHOTGRAPHS FOR TEACHING TRAINING AND PAID  
ADVERTISEMENTS**

I \_\_\_\_\_ (CLIENT NAME HERE)

Authorized Dr. Tim Roham to use any photographs taken of me before and after my procedure for teaching, demonstrations, to share with patients and for any and all printed material that Dr. may advertise in.

I know and understand that Dr. Roham intends to use my photos for professional advertising and my pictures may be shown in a front and side profile, in color or black and white. I understand and acknowledge that Dr. Roham will be using the photos of my face, or body part for financial gain.

\_\_\_\_\_  
(CLIENTS NAME HERE)

\_\_\_\_\_  
Date