Women's Choice
Aesthetics ✳ Mammography

Acknowledgement of Practice Policies

I understand that I will receive cosmetic medical treatment from Neil T. Specht, M.D, and/or Evangeline S. Specht M.D., and/or Miranda Vincent, APRN, doing business as Women's Choice Aesthetics. The various treatments the Practice provides include laser hair reduction, laser skin rejuvenation/IPL, microneedling, microdermabrasion, varicose vein treatments, PRP, facials, chemical peels, Botox/Dysport Cosmetic injections, dermal filler injections, body contouring, vaginal rejuvenation, and tattoo removal. I understand that depending on the treatment I select, I will be required to sign an informed consent specific to that treatment: ________(please initial)

I am fully aware that my condition is solely of a cosmetic nature and that the decision to proceed is based on my expressed desire to do so: ____________ (please initial)

Payment Policy

I understand that my treatments require payment at the time of visit. The prices and fee structure for treatment will be explained to me at the time of my consultation. The quoted price for treatment is the price for each individual treatment session, unless otherwise specified in writing. I understand that the services may require more than one session and I have the option of purchasing a package if available. There are no refunds on treatments paid in advance. I further understand that the services offered are elective by nature and not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. We accept payment in the form of cash or major credit card _____ (please initial).

Disclaimer

I understand that all medical cosmetic treatments are provided exclusively by Neil T. Specht, M.D, and/or Evangeline S. Specht M.D., and/or Miranda Vincent, APRN, (doing business as Women's Choice Aesthetics), an independent medical professional corporation. I will not hold Women's Choice Aesthetics, its owners, or its employees responsible for the results I experience. I realize that results may vary. I further understand that Women's Choice Aesthetics can't prescribe an exact number of treatments to satisfy each individuals opinion and that the number of treatments I complete will be at my own discretion: _____ (please initial).

I have read and fully understand all the terms of this Acknowledgement of Practice Policies form, all my questions have been answered to my satisfaction and I agree to the terms of this consent.

Print Client Name: ____

Client Signature: ____ Date: ________________

I have explained the above statements to the client and answered all questions.

Print Clinical Staff Name: ____

Clinical Staff Signature: ____ Date: ________________

Photo and Video Release Form

I, hereby give my permission to Women's Choice Aesthetics and Mammography and his/her employees, or any person, that he/she may designate to take photographs, digital images, and/or videos of me (patient name) ______________________ or if applicable my (son/daughter name)______________.

This consent includes the use of such photographs, images, or videos without my name for procedure evaluation, patient discussion, and medical educational purposes regarding the aesthetic procedure. Additional acceptable uses for such images and videos are initialed below.

1. Photo Book ______
2. Website or social media sites ______
3. TV Broadcast ______
4. Digital/Print article or publication ______
5. Advertisement ______

Patient Name: _______________________________________

Name of Parent/Guardian (if Applicable): _________________

Signature: ____ Date: ________________________

Witness Name: ______________________________

Witness Signature:____________________________ Date:_______________________

Credit Card Authorization

This document is to authorize Women's Choice Aesthetics to keep a copy of your credit card information on file to bill for charges related to no shows or cancellations without adequate notification.

Women's Choice Aesthetics is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at (202)-445-0101 by 2pm on the day prior to your appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2pm on Friday. If prior notification is not given, you will be charged $25 for the missed appointment.

By signing below, I agree to the terms of the authorization as written above.

Name:____ Date:__________________________

Signature:____

Name on Credit Card:____

Type: AMEX VISA Mastercard Other:________

Expiration Date:_____________ Security Code:_______________

Signature:____

Updated: June 2020

Women's Choice Mammography

Consultation Sheet

Name: ____ DOB:_____________________

Date:	Notes:

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HEALTH HISTORY INFORMATION

Last Name: ___________________________ First Name: _________________________ MI: _____

Street Address: ____

City: ____________________________________ State: _________ Zip Code: _______________

Date of Birth: ____________________________ Age: ___________ Sex: ☐ Female ☐ Male

Phone: Home ____________________ Cell ____________________ Work ____________________

Primary Care Physician: ___________________________________ Phone: ___________________

*Email: ____

*May we contact you regarding promotions, specials, or events? ☐ Yes ☐ No
PRIVACY: We will only use your email address for internal marketing purposes; we never share our patients' information

How did you hear about us? ____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. Do you have ANY of the following current or chronic medical illnesses?

☐ Asthma
☐ Thrombophlebitis
☐ Heart attack (MI)
☐ Migraines
☐ Numbness
☐ Fainting or dizzy spells
☐ Autoimmune disease
☐ Hepatitis (Type ___)
☐ Arthritis
☐ Tumors/Cancer
☐ HIV / AIDS
☐ OTHER: ____________________

☐ Pulmonary Embolus (PE)
☐ High blood pressure
☐ Diabetes
☐ Headaches
☐ Muscle weakness
☐ ALS
☐ Eye disease
☐ Bleeding disorders
☐ Anaphylactic shock
☐ Easy bruisability
☐ Skin diseases

☐ Deep Vein Thrombosis (DVT)
☐ Heart disease
☐ Stroke
☐ Seizures or convulsions
☐ Neurologic disorder
☐ Myasthenia Gravis
☐ Vision problems
☐ Septicemia
☐ Hives
☐ Dark spots after pregnancy

2. What medications or herbal supplements do you take on a regular basis?

____
____
____

3. Are you using ANY of the following topical products?

☐ Retin-A®
☐ Renova®

☐ Tazorac®
☐ Avita®

☐ Alpha or Glycolic Acids
☐ Vitamin C

4. Do you have ANY allergies?

☐ Eggs
☐Medications: ____________________

☐ Latex
☐Foods: __________________________

☐ Tape/Adhesives
☐ Other: __________________________

5. Medical History

Question	Yes	No
(For women) Are you or could you be pregnant?	☐ Yes	☐ No
(For women) Are you lactating and/or breastfeeding?	☐ Yes	☐ No
(For women) Are your menstrual periods regular?	☐ Yes	☐ No
Do you have a history of Herpes I or II in the area to be treated?	☐ Yes	☐ No
Do you have a history of cold sores or canker sores?	☐ Yes	☐ No
Do you have a history of keloid scarring?	☐ Yes	☐ No
Do you have, or have you ever had vitiligo (loss of skin pigment)?	☐ Yes	☐ No
Have you taken Accutane or anticoagulants in the last 6 months?	☐ Yes	☐ No
Have you had unprotected sun exposure, used tanning creams or tanning beds in the last 4-6 weeks?	☐ Yes	☐ No
Do you have any permanent makeup, implants, or tattoos?	☐ Yes	☐ No

If yes, please list type and location(s): ______________________________

6. Social History

Do you smoke? ☐ Yes ☐ No If yes, how much? ____________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? ____________________

Do you exercise? ☐ Yes ☐ No

Occupation: ______________________________

7. Please indicate which of the following concerns you have about your skin:

☐ Aging skin
☐ Redness
☐ Rosacea
☐ Sun damage
☐ Skin laxity
☐ Dark under-eye circles
☐ Other: ____________________
☐ Skin texture
☐ Fine lines / wrinkles
☐ Pigmentation
☐ Hands (loss of volume, veins, discoloration)
☐ Scars / acne scars
☐ Hair removal
☐ Spider veins (face or legs)
☐ Stretch marks
☐ Acne

8. Please indicate the service(s) in which you are interested or on which you would like more information:

☐ Hydrafacial
☐ Microdermabrasion
☐ Dermaplaning
☐ Chemical Peels
☐ Laser Hair Removal
☐ Laser Skin Rejuvenation
  ☐ Lasergenesis
  ☐ Picogenesis
☐ Laser Treatment for Hyperpigmentation
☐ Microneedling RF (secret RF, Morpheus)
☐ Tattoo removal
☐ Body Contouring
  ☐ TruSculpt iD
  ☐ TruSculpt FLEX
  ☐ Endymed Skin Tightening
☐ Platelet Rich Plasma (PRP treatment) for
  ☐ Hair Loss
  ☐ Urinary Incontinence
  ☐ Joint/Tendon Pain
  ☐ Sexual Health
☐ Votiva- Vaginal Rejuvenation for
  ☐ Urinary Incontinence
  ☐ Pain with Sexual Intercourse
  ☐ Dryness
☐ Vein Treatment
  ☐ Laser for Spider Veins (face/legs/body)
  ☐ Sclerotherapy
  ☐ Closure Fast
☐ Skincare Products
☐ OTHER: ______________________________

9. Have you ever had any of the following treatments?

☐ Botox® / Dysport®: Date of last treatment: ______________________

☐ Dermal filler:_________________ Date of last treatment: ___________________ Type/Area: _____________________________

☐ IPL Date of last treatment: ______________________

☐ Laser hair reduction Date of last treatment: ______________________ Area: _______________________________________

☐ Chemical peel Date of last treatment: ______________________ Type/Area: ________________________________

☐ Laser treatments Date of last treatment: ______________________ Laser Type: ________________________________

Area(s): _____________________________________ Reason: _____________________________________

☐ Microdermabrasion Date of last treatment: ______________________

☐ Sclerotherapy Date of last treatment: ______________________

☐ Cosmetic surgery Date of last treatment: ______________________ Type/Area: ________________________________

10. Skin Care

Do you regularly wear sunscreen? ☐ Yes ☐ No

Do you feel that your current products are successfully treating your skin conditions and concerns? ☐ Yes ☐ No

Do you have a regular skin care regimen? ☐ Yes ☐ No

If yes, describe and list products used:

____

____

LIMITATION OF TREATMENT

The practice of Women's Choice Aesthetics, LLC and any and all services provided by Neil T. Specht, M.D., LLC and/or Evangeline S. Specht, M.D., LLC is strictly limited to cosmetic procedures. By my signature below, I acknowledge that the practice **does not examine or treat for malignancy (cancer)** or non-cosmetic skin abnormalities. Skin cancer is an extremely serious (potentially fatal) condition and must be treated **immediately**. I understand and acknowledge that it is my responsibility to schedule regular examinations with a dermatologist, and to bring any concerns regarding skin changes or skin cancer to their attention immediately.

It is my responsibility to inform the treating physician should I become pregnant at the time of any of my treatments, as pregnancy is a contraindication to many of the treatments and facial products that may be used.

I have been informed of payment policies. I understand that pre-payment is required for all cosmetic and body sculpting services and that I am financially responsible for all procedures. I understand that there is no refund for pre-paid services. My signature below signifies my understanding and willingness to comply with this policy.

______________________________	______________________________	____________________
Client Signature	Client Name (please print)	Date

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Skin Type Classification Questionnaire

Patient Name: ______________________________ Today's Date:____________________

Score		0	1	2	3	4
	What is your natural hair color?	Sandy red	Blond	Chestnut, dark blond	Dark Brown	Black
	What is your eye color	Light blue, light gray, light green	Blue, gray, green	Brown	Dark brown	Brownish black
	What is your natural skin color on areas protected from sun exposure?	Reddish	Very pale	Pale with beige tint	Light Brown	Dark Brown
	How many freckles on unexposed skin areas?	Many	Several	Few	Incidental	None
	What happens when you are exposed to the sun too long without protection?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem
	How well do you tan?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly
	Do you turn brown within one day of sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun or artificial sun treatments?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Seldom	Sometimes	Often	Always
	Total					

Skin Type Score	Fitzpatrick Skin Type	Typical Ethnic Background
0-7	I	Irish, English, Scottish
8-16	II	Irish, English, Scottish
17-25	III	Dark Caucasian, light Asian
26-30	IV	Hispanic, Asian, Native American, Mediterranean, light Middle Eastern
31-35	V	Latin, Pacific Islander, dark Middle Easter, light African American
36+	VI	Dark African America

Client Signature ____________ Client Name (please print) ____________ Date ____________

Provider Signature ____________ Provider Name (please print) ____________ Date ____________

Revised June 2020