A Healing Point Acupuncture Center, PLLC

1329 Howland Blvd., Deltona, FL 32738 ~ Ph: 407-476-1818 ~ Fax: 321-476-1818
www. AHealingPointAcu.com

purHenna Brow Tint

CLIENT INFORMATION FORM

APPOINTMENT DATE ☐ APPOINTMENT TIME ☐

FULL NAME

ADDRESS

CITY

STATE / PROVINCE

ZIP / POSTAL CODE

PHONE

EMAIL ADDRESS

DATE OF BIRTH (DD/MM/YYYY)

CURRENT AGE

Have you ever used any Henna Products in the past? ☐ yes ☐ no
If YES, when did you have your last application?

____

If YES, was it a good experience? ☐ yes ☐ no
If NO, please describe:

____

____

Have you ever used purHenna tint before? ☐ yes ☐ no

If YES, did you experience any reaction to the tint?If YES, please describe: ☐ yes ☐ no

____

____

Which best describes the look you would like to achieve for your brows?

☐ Full & Thick ☐ In Between ☐ Soft Natural

CLIENT INFORMATION Continued

For a more effective, personalized treatment, please be as accurate as possible when filling out the following information

PLEASE CHECK ANY OF THE FOLLOWING THAT MAY APPLY TO YOU:

RELATING TO THE EYE

- ☐ Eye surgery
- ☐ Eye illness or injury
- ☐ Dry eyes
- ☐ Seasonal allergies
- ☐ Eye infection
- ☐ Permanent eye make-up
- ☐ Blepharoplasty
- ☐ Blepharitis (in flammation of eyelids)
- ☐ Allergies to adhesives found in band-aids or medical tape
- ☐ Allergies to preservatives in saline solutions
- ☐ Sensitivity or claustrophobia when your eyes are closed for long periods of time
- ☐ Retinoids used to treat acne and skin problems (such as accutane or retin a)

GENERALLY RELATING TO Hair Loss

- ☐ Hormone imbalance
- ☐ Recent severe illness or injury
- ☐ Pregnancy or recent childbirth
- ☐ New prescriptions or recently prescribed oral contraceptives
- ☐ Types of medical conditions that may contribute to hair and eyelash loss: hyperthyroidism or hypothyroidism, alopecia areata, lupus, diabetes
- ☐ Vitamin and mineral deficiencies that may contribute to hair and eyelash loss: A, F, B, Selenium, Zinc, Iron
- ☐ Trichotillomania (hair pulling disorder)
- ☐ Medications that may contribute to hair loss: chemotherapeutic agents used in cancer treatment, Anticoagulants (blood thinners), beta blockers (used to control blood pressure)

Other Medical Information:

____

____

BEAUTY REGIME

Please check all of the below products you use:

☐ Lash/Brow Growth	☐ Waterproof eyebrow Mkup / Regular Pwdr	☐ Brow Mkup Liner
☐ Serum Brow Curler	☐ Oil-Based Products (creams, rem overs, etc)	☐ Contact Lenses

Please describe any helpful information about your brows.

____

____

PHOTO/VIDEO CONSENT FORM

I, ______________________ , hereby grant permission to the rights of my image, likeness and sound of my voice as recorded in audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed. I waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

PHOTOGRAPHIC, AUDIO, OR VIDEO RECORDINGS MAY BE USED FOR THE FOLLOWING PURPOSES:

- Educational presentations or courses
- Informational presentations
- Online educational courses
- Educational videos
- Promotional materials

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the internet or in the public educational setting.

- [ ] I will be consulted about the use of the photographs or video recordings for any purpose other than those listed above.
- [ ] There is no time limited in the validity of this release nor is there any geographic limitation on where these materials may be distributed.
- [ ] This release applies to photographic, audio, or video recordings collected as part of the sessions listed on this document only.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

CLIENT'S NAME (please print) : ______________________ CLIENT'S SIGNATURE: ______________________

DATE: ______________________

CONSENT FOR *BROW Henna Application*

I UNDERSTAND /AGREE TO THE FOLLOWING COMPLETELY: (PLEASE INITIAL EACH STATEMENT)

_________ I agree to have an eyebrow henna applied to my natural brows and/or retouched.

_________ I consent to the procedure of an eyebrow tint.

_________ I understand there are risks associated with having an eyebrow tinting procedure with Henna.

_________ I understand that as part of the procedure, skin irritation, skin pain, skin itching, discomfort, and in rare cases skin infection could occur. I agree that if I experience any of these medical conditions with my brows that I will contact the office at 407-476-1818 immediately and consult a physician at my own expense.

_________ I understand that even though my technician tinting with Henna and using the proper technique, the instruments, tapes, cleaners, dyes and removers used may irritate my skin or require a physician's follow-up care.

_________ I understand and agree to the care instructions provided by my technician for the use and care of my tinted brows.

_________ I realize and accept the consequences of failure to adhere to the aftercare instructions may cause my brows to not stay tinted as long as told.

_________ I understand and consent to having my eyes closed and covered for the duration of the 45-60 minute procedure.

_________ I release my technician from all liability associated with this procedure, which is performed with the utmost attention to safety and proper application using tools and products that the technician has been professionally trained to use.

_________ I understand there are no guarantees for length of time the brows will stay tinted. On average the duration has been anywhere from 4 to 8 weeks. Results can vary.

_________ I understand the aftercare instructions and will do my part to maintain my results.

_________ I understand that there are many factors that may affect the life of the brow tinting such as excessive water, moisture, sun/UV/Tanning contact, weather conditions, and activities involving exposure to high temperatures.

By signing below, I verify that I have read and understand the above statements and agree to them.

______________________________	______________________________
Client Name (please print)	Client Signature
______________________________	Yolanda Carrillo
Day/Month/Year	Permanent Makeup Technician

PRECAUTIONARY COVID-19

LIABILITY RELEASE FORM

Due to the 2019 - 2020 pandemic of the coronavirus (COVID-19), we are taking extra precautions as we proceed with each client. We will be implementing additional sanitation and disinfecting practices. Please read, complete the following, and sign below.

SYMPTOMS OF COVID-19 INCLUDE AND ARE NOT LIMITED TO:

- FEVER
- FATIGUE
- SHORTNESS OF BREATH
- DRY COUGH
- SORE THROAT
- BODY ACHES / PAIN
- HEADACHE

I, ____________________________, AGREE TO THE FOLLOWING:

_______ I agree to have my temperature taken and to reschedule my appointment if my temperature exceeds the normal range of 96 – 99 Degree Fahrenheit.

_______ I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced symptoms listed above within the last 14 days.

_______ I affirm that I, as well as all household members, have not traveled outside of the country, or to any known COVID-19 "hot spot" states in the last 30 days.

_______ I agree to wear a protective mask for the duration of my visit.

_______ I understand my technician will not be liable for any exposure to the virus or any other contagion during my visit.

_______ I affirm my procedure is elective and in no way medically necessary. I chose to be here on my own free will.

My signature below indicates I agree to each of the above statements and release my technician and the business from any and all liability for the unintentional exposure to COVID-19 virus.

CLIENT'S SIGNATURE:______________________ DATE: ______________________

Your technician and all employees of this facility agree that they abide by these same standards and affirm the same. We also affirm that we have improved and expanded our sanitation protocols to more thoroughly prevent the spread of COVID-19 and other communicable conditions.

FOR PROFESSIONAL USE

CLIENT *purHenna Brow* TINT
INFORMATION

File Categorically by
First Letter Of
Clients Last Name

FILE

CLIENT FULL NAME

ADDITIONAL NOTES:

CLIENT EYE SHAPE

☐ Round ☐ Thin ☐ Oval ☐ Deep Set

Notes:

☐ ☐ ☐ ☐

Henna Brow TREATMENT TIME (IN MINUTES) ______________

NATURAL BROW COLOR

☐ Blonde ☐ Black ☐ Red ☐ Brown

purHenna Brow TINT COLOR Choice:

____

____

____

FOLLOW UP NOTES: (IRRITATION, FADING, ETC)

PRICING

purHenna
Brow Tint ______________

TINT: ______________

OTHER: ______________

SPECIAL PRICING

(PROMOTIONAL DISCOUNT
IF APPLICABLE)

____

OFFICE POLICIES

NO SHOW/LATE CANCELLATIONS If an appointment is missed or not cancelled with 24 hours prior notice to the scheduled time, a fee of $55.00 will be charged. All "no-show" or "late cancellation" fees are to be paid in full on or before the next visit. Insurance will not reimburse the patient for this charge, nor will we bill the insurance for the visit. Our office staff makes appointment confirmation by phone as courtesy to our patient. Nevertheless, it is the patient's responsibility to remember his/her appointment date and time.

AFTER-HOURS APPOINTMENTS All appointments made outside regular hours require staff to come in on their day off or after hours. Should you miss or cancel an after-hour appoint you may be charged for the entire visit there are no exceptions. A credit card may be required to hold your appointment and it will be charged the full amount of your visit should you not show or cancel outside a reasonable time.

MEDICAL RECORDS RELEASE Should you need copies of your records or other documents including receipts and income tax-related documentation, please note the following in accordance with Florida Statute: For copies of chart pages, a minimum of ten (10) working days and not more than thirty (30) is required to process your request. A completed and signed record release must be done before any records are released. If records are not being directly released to another physician's office, there will be a fee of $2.50 per page for the first 10 pages and 0.90 cents per page after that, payable prior to release of your copies. Reproduction of photographic materials will require additional time over and above ten (10) days. Any reproduction of photographic materials will be billed to you at the cost of reproduction, payable prior to release.

AFTER HOURS AND EMERGENCIES In the event of an emergency situation, call 911 or go to the nearest Emergency Room. If you have an urgent concern that you need to discuss with the physician, please call our office to schedule your appointment. A" phone message left in the voicemail will be returned within 24 hours by the office Tuesday - Saturday. We are closed Sundays and Mondays and major holidays.

POLICY REGARDING SMALL CHILDREN. We love children at A Healing Point Acupuncture Center, PLLC; however, due to safety and noise issues we ask that all children under the age of nine (9) be left at home. The exception is children receiving treatment. Zen-like moments can be disturbed by fighting or crying children and parents will have a difficult time relaxing when worried about the little ones. For safety reasons children are prohibited from waiting in a treatment room while parents/guardians receive treatment.

TREATMENT OF MINOR CHILDREN. Children under twelve (12) being seen for treatment MUST be accompanied by a parent or guardian who is legally able to consent to treatment and make medical decisions on behalf of the minor child.

FAMILY & FRIENDS IN THE TREATMENT ROOM. With the exception of a parent accompanying a minor or a caretaker accompanying a disabled or unsteady individual. Family and friends are asked to wait in the lobby.

COMPLAINCE A treatment plan will be tailored to your condition. Missing appointments and otherwise not adhering to your treatment plan will interfere with your progress. Patients who deviate from the prescribed treatment plan may be discharged for non-compliance.

REFUNDS. Refunds on herbs will only be offered if they are returned within seven (days) of the date of purchase and are unopened, with the seal still intact. There are no refunds on services or opened products for any reason. Refunds on remaining package treatments will be refunded at the amount of the regular/full price service, not the discounted price as the package pricing would no longer apply.

TIMED SERVICES Massage and timed services are timed per industry standard. 50 minute hour and 25 minute half hour. Time to disrobe and conduct intake is factored in. To get the most time out of your service, please arrive at least 15 minutes prior to your service to allow time for check in. To get the most hands-on service time it is recommended you do not wait until your service is to start to arrive/check in and/or use the restroom. Services will not be extended to accommodate late arrivals as there is likely another service booked following yours. A timer is kept visible in each treatment room. Please monitor the time display on the timer as you may be required to sign for timed services (if we are billing your insurance.)

TURN OFF CELL PHONES. To help promote our relaxing atmosphere, we require phones be turned off or on vibrate while inside the clinic and no phone calls during treatment. Phone calls should be taken outside. Rest, relax, breathe and disconnect. Let the healing being.

FORMS AND REPORTS There will be a $50-$60 administrative fee for forms such as disability reports and letters of medical necessity. The fee will be determined based on the complexity of the document. Please allow seven (7) to ten (10) days for these reports to be completed. RECIPTS & TAX DOCUMENTS Please save your receipts. Each year we get dozens of requests from patients who lost or failed to save their copies. The forms and reports fees apply to compiling of copies of receipts and payment information.

CHECK POLICY. No personal checks will be accepted on NEW PATIENT visits. Any returned checks will incur a $50.00 minimum returned check fee. In the event the account becomes delinquent and is turned over to a collections agency, there will be a $95.00 fee for each account and you are responsible for any collection, court, or attorney fees. It is the responsibility of the patient to fully understand the rules and regulations of their insurance company and plan coverage.

I, ____________________ have read the above policies and understand my rights and agree to abide by said policies.

____________________	____________________	__________
Printed Name	Signature	Date

Copy of this document available upon request

Financial Responsibility / Assignment of Benefits

I hereby authorize Dr. Yolanda Carrillo, AP, DOM and/or any other licensed provider at A Healing Point Acupuncture Center, PLLC (hereinafter "Provider) to furnish acupuncture, massage therapy, ultrasound therapy, kinesiology taping, neuromuscular or manual therapy, injection therapy as long as said method of treatment falls within said provider's scope of practice. Moxibustion, Gua Sha, cupping therapy and/or various other therapeutic treatments and any other therapies within the provider's scope of practice including but not limited to recommending herbs and supplements.

I authorize Provider to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers, or attorneys.

I authorize Provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf should the provider feel there is a valid reason for doing so.

I understand that I am responsible for paying time of service charges, my co-payments, co-insurance and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company. I understand that my insurance company may not cover my all or part of my visit and treatment. Should they not cover it, I understand that the money I have paid is only an estimate of the amount that my insurance company may say now, and that the Provider will bill me for the amount due, per my insurance company. I also understand that should my insurance allow and pay for the acupuncture treatment and decide I owe less than what I have paid the provider, that the provider will refund me the difference between what I paid and what the insurance company says I owe. I also understand that because the Provider may be out of network I agree not to request a refund from the provider should the insurance company pay all or part of my visit and subsequent treatment; unless the insurance company indicates that I am due a refund. **I also agree that should my insurance company send a check to me, I agree to immediately turn those funds over to the Provider & or A Healing Point Acupuncture Center, PLLC.**

I understand that the Provider will bill my insurance carrier for services rendered. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payment within 60 days, I understand that I will be responsible for the balance due in full.

I hereby request that my insurance carrier make payment directly to A Healing Point Acupuncture Center, PLLC or the rendering physician for all services rendered by this facility. If my current policy prohibits direct payment to Provider, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to Provider.

If my insurance carrier makes payments to me I agree to immediately pay over these funds to Provider. I also authorize Provider, to deposit any check(s) received on my account when made out to me and bearing my endorsement.

I understand and agree that if I fail to make any of the payments or turn over funds paid to me by my insurance for which I am responsible in a timely manner, I will be held responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Charges related to Workers Compensation injury shall be forwarded to the Workers Compensation Insurance carrier and I will not be held personally responsible for these charges. I understand that if I claim Worker's Compensation benefits and those benefits and are subsequently denied, I may be held responsible for the total amount of charges for services rendered.

Benefits Provider receives from my insurance carrier at the time of service are not a guarantee of benefits. I understand and acknowledge that as the patient, legal guardian or parent (if the patient is under 18 years old) I will be responsible for the co-payment and the deductible at the time of service.

______________________________ ________________

Patient or if a minor, Patient's Guardian Date

Privacy Policy

All records are kept strictly confidential and are subject to HIPAA compliance and will not be shared with any outside establishment, individual, organization or medical facilities without explicit **written** consent from the client (you) or the client's legal guardian. Unless legally required by local, state, or federal subpoena, summons or other court order. Copies of our detailed Privacy Policy is attached and additional copies are available upon request, are posted online and are posted near the front desk and are on most intake clipboards.

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of A Healing Point Acupuncture Center, PLLC Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in A Healing Point Acupuncture Center, PLLC Notice of Privacy Practices, please do not hesitate to contact a clinic representative of A Healing Point Acupuncture Center, PLLC Patient Privacy Officer as indicated on your Notice.

____________________________________ ____________________

Patient Name/Patient Representative (Printed) Date

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Signature of Patient/ Guardian / Custodian
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