Reuben I Thaker MD PLLC dba Phaze Laser Med Spa, dba Thaker Cosmetic and Wellness

Informed Consent for Treatment

I, _____consent to and authorize Reuben I Thaker MD PLLC, dba Phaze Laser Med Spa ('Company') to perform today and henceforth, single as well as ongoing treatments, services or procedures ('treatments'), whether of a medically necessary and or cosmetic nature, this may further include but is not limited to anything handwritten here_____. Treatments may use laser, light, water pressure, mechanical needling or abrading, chemicals, medications, surgical procedures, energy based and or other technology. You agree cosmetic procedures are not medically necessary. Further, becoming our cosmetic client, does not constitute treatment of any medically necessary condition, nor create of itself an ongoing doctor-patient relationship with Company nor medical staff. Further, you are aware that many treatments, in medical or cosmetic use, are not FDA approved and are considered 'off label' use. You agree to any such usage without further notice.

You have the right to be informed about your treatments so that you may proceed or decline after considering the risks. This disclosure informs you about risks, benefits, alternatives, side effects and complications which may occur with any and all treatments:

1. **The possible risks of services, treatments or procedures include but are not limited to** pain, infection, bleeding, swelling, redness, bruising, blistering, scarring, scabbing, hair or skin changes, or other unforeseen complications which can be lasting or permanent, worsening or incomplete resolution of the problem. Treatment of these may cause you other costs.
2. **There is a risk of scarring.** Changes in appearance, texture or color of skin can be permanent.
3. **Pain:** methods to minimize pain are offered though no procedure is deemed painless.
4. **Infection:** infection following treatment may require added treatments or antibiotics.
5. **Bleeding:** more than minor bleeding is rare but occurs. Follow after-care instructions to minimizes such risks.
6. **Allergic Reactions:** substances within or on skin, can induce severe allergic reaction with initial or later treatments, whether medical, cosmetic, laser, or otherwise. Notify us of any tattoos, scars, or substances used on skin.
7. Brown/red darkening ('hyperpigmention') or lightening ('hypopigmentation') of skin can occur anytime and be permanent.
8. Lasers or other treatments can blind or harm eyes. You will wear issued eye protection during all laser treatment.
9. Any treatment plan depends on your participation and always providing full and accurate information. Compliance with aftercare is crucial for healing and to prevent complications. It is your responsibility as patient.
10. No guarantee of results has been made or implied. Most problems can be improved, but may require many treatments. There is a risk of death, severe bleeding or infection, or total failure of treatment. While these risks can be unpredictable, such risks are generally low. If any of these risks are highly substantial, then you may be declined such treatment.

We often take photos or videos to document, assess, or use otherwise, regarding your treatment. You expressly authorize us to publish these at our discretion for promotion, education, or other uses. These may include age, sex, treatment details but will not unnecessarily identify you. We also may document services rendered in office, by phone or by video ('telemedicine'), by audio or video methods. You agree by signing, this is within the allowed uses of the **HIPAA notice of privacy practices** you received, incorporated herein by reference. No patient cell phones or electronic device usage is allowed during any service nor in treatment rooms.

Acknowledgement: My questions regarding treatment, procedures or services have been answered satisfactorily. I understand and accept all risks. It is my ongoing obligation to advise Company if at any time I do not wish to proceed with treatment offered by Company. I hereby release Reuben I Thaker MD PLLC, dba Phaze Laser Med Spa ('Company'), its staff, and medical director from all liabilities associated with any treatments, procedures or services performed on this or any subsequent date.

Name:_____**Sign:**_____**Date:**_____

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Consent for Treatment and Authorization of Payment

CONSENT FOR TREATMENT
I authorize and consent to the administration and performance of all services, procedures, and treatments, that may be ordered and or performed by Reuben I Thaker MD PLLC, physician or non-physician personnel. Regarding services, cosmetic, esthetic, medical or otherwise, individual results vary. No guarantee of results is made or implied. Parents must accompany minors, unless contravened by Law. We reserve to the right to refuse or terminate service to disruptive persons and no refund will be granted.

ASSIGNMENT OF BENEFITS FOR MEDICAL SERVICES
In consideration of these medical services, I hereby assign, transfer and set over to Reuben I Thaker MD PLLC, all my rights, title and interest to medical reimbursement benefits under my health insurance policy (s). If my insurance benefits are provided through an ERISA plan (Employment Retirement Income Security Act) I hereby assign, transfer, and set over all my rights, title and interest as beneficiary of ERISA plan to Reuben I Thaker MD PLLC, regarding applicable treatment by Reuben I Thaker MD PLLC and or staff.

PAYMENT AGREEMENT
All sales final. I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the undersigned, to Reuben I Thaker MD PLLC dba Phaze Laser Med Spa. I understand and agree this a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. Any assignment of benefits of any insurance or medical reimbursement plan shall not be deemed waiver of Reuben I Thaker MD PLLC' s right to require payment directly from the undersigned, and we expressly reserve this right. If such obligation remains unpaid, the undersigned agrees to pay all costs of collection, including, but not limited to attorney's fees. If the undersigned is more than one person, every obligation hereunder shall be joint and several. We reserve the right to refuse service to disruptive persons and no refund will be granted.

Payment is due at the time of service. This may include deductible, copay, coinsurance, non-covered service payment, services to private pay patients, cosmetic or other payments. This requirement is enforced, unless contravened by law. Medicare and insurances require us to collect fees owed by patient. You are responsible for payment regardless of any insurer's determination of rate, unless a participating agreement applies. We will provide a receipt you may submit to insurer, which may or may not reimburse you.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR PAYMENT AND OR OTHER PURPOSES
I authorize Reuben I Thaker MD PLLC to release medical information and copies from my medical record at any time to insurance companies, third party payers, authorized agents, or others reasonably related to payment of services; to claims review organizations; to employer insurance companies or designees regarding medical service; or to comply with professional review organizations. By signing I acknowledge and consent to all sections on this page, and further that I received the **HIPAA Notice of Privacy Practices**, incorporated into this Consent by reference. I may write to revoke my authorization at any time.

My signature below is authorization to process this credit card for charges at time of service, for the duration of my tenure as a patient or client of Reuben I Thaker MD PLLC, dba Phaze Laser Med Spa, including cosmetic services; and or private pay medical services; and or insurance related charges such as co-payments, co-insurance, deductible, or any other non-covered charges; and appointment cancellation charges . You agree we may charge $1 to verify card is active, which becomes a $1 credit balance for services here. You agree we retain your credit card information for future charges. Cosmetic service payment is due in full prior to service and is not covered by insurances. Further, all sales final. Practice follows applicable insurances billing policies for medically necessary services, if any. Further, I am financially responsible for any charges of any kind not covered by insurances.

Credit Card Information

Credit Card Type _____ #_____ Exp_____/_____
Name on card_____ 3 digit code_____
Cardholder's Billing Address_____ ZIP_____
Cardholder Signature:_____ Date:_____

Signature indicates the undersigned has had all questions answered , consents and agrees to all terms above.

Name:_____Sign:_____Date:_____

Reuben I Thaker MD PLLC dba Phaze Laser Med Spa, dba Thaker Cosmetic and Wellness

Personal and Medical History

Name _____ Date of Birth_____Age____Today's Date _____

Phone (____)_____ Email_____Occupation_____

Home Address_____City_____State____Zip _____

Social Security #_____ Emergency Contact and Phone to notify in emergency_____

Circle how you heard about us: Internet Search Term: _____Facebook Instagram Yelp Youtube Ad TV REFERRAL: _____

MEDICAL HISTORY Do you have any medical problems? (Please mark and then verbally describe all.)

□Yes □No Are you now under care of an M.D., dermatologist, surgeon, PCP or other? Who and for what? _____

□Yes □No Have you had prior cosmetic procedures? procedure/date_____ procedure/date_____

□Yes □No Have you ever had unsatisfactory medical, surgical, med spa, laser or cosmetic service? procedure/date_____

Circle your skin type:

I	Always burns, never tans	IV	Rarely burns, always tans
II	Always burns, sometimes tans	V	Brown, moderately pigmented skin
III	Sometimes burns, always tans	VI	Black skin

□Cancer □Diabetes □HIV/AIDS/Hepatitis B/C □Heart attack or stroke □Heart or lung disease or asthma □Seizures □Joint pain □ Migraines

□ Hair loss □Herpes □Cold sores □Any active infection □Accutane □Skin cancer/disease □Sunburn or suntan past 2 weeks □Raised/ keloid scars

□Darkened/lightened marks on skin □Blood clots or bleeding disorder □Personal or family problems with anesthesia □Smoking or tobacco use

□ short of breath □ chest pain □ vomit/abdomen pain □Attempting or now pregnant □Breastfeeding □ Tattoos: year and professional/homemade:

□Anxiety or psychiatric condition □Drug use [includes marijuana or alcoholism]_____ □ fatigue or tiredness □ weight gain/ loss

□Any other conditions, list AND verbally describe to us:_____

ALLERGIES to medication or other allergies: _____

MEDICATIONS

List all medications or over counter items used:_____

List all topical medications or creams used: _____

Medical services- Primary Insurance: _____Policy # _____ Grp #_____

Claims tel#_____ Address on back of card _____

Medical services- Secondary Insurance: _____Policy # _____ Grp #_____

Claims tel#_____ Address on back of card _____

Preferred Pharmacy Address:_____ tel:_____ fax:_____

I certify my preceding statements are true and complete. It is my responsibility to inform and update all staff involved, of my health conditions. I am financially responsible for all charges not paid by applicable insurances. No cosmetic services are paid by any insurances.

Name:_____**Sign:**_____**Date:**_____

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Other Notices

No Emergency Services Provided If you have a medial emergency, call 911. During a national health crisis or similar occurence: you must follow our office safety regulations or we may cease services at once without refund; we may work 'by appointment only', and we may perform screening and or health evaluation for your safety or general safety, and you agree to this without further notice.

Scope of Medical Service [non cosmetic services] Calls are answered during posted business hours, within one business day or when possible. Physician provides non-emergency, outpatient services only. For medically complex patients, visits are generally offered monthly. For solely episodic medical care, you must have another primary physician. If you miss a scheduled appointment, you must attend a medical visit here within 30 days. If you do not, you agree we may consider the doctor-patient relationship, if any, to have been terminated by you, and further that we owe you no further services, nor further notice of this.

Cosmetic Services [non-medically necessary services] All sales final. No guarantee of results is made or implied. Cosmetic services, are laser, esthetician, or other beautification services, which are without medical necessity and thus non-medical in nature. Thus you do not have a patient-doctor relationship with our physician. Contact us regarding our services, and your own physician for all other medical care. **All laser or other packages:** Your first session is due 30 days from purchase. Each session thereafter is due within 4-6wk, or it is forfeit, whether you did not schedule, cancel, no show, or any reason. All of 6 sessions expire 6mo from first session due, all of 4 sessions expire 4mo from such, etc. This means a session is due at 4-6 weeks, and then expires. Reinstatement is $50 to resume service. We may reinstate forfeit session if comparable value. If we judge you justifiably cannot finish a package, then from any refund, used sessions are deducted at full retail value of 200% of their package value.

Notice regarding records You agree to keep a medication list with you at all times, to provide other medical entities. You agree to assist us to obtain your records from other medical entities. You may request and be provided a patient website portal, in certain situations. We do not facilitate nor monitor your use. Copies are $0.50/page, unless contravened by law.

Notice regarding medical director time [non-insurance covered services] Medical director charges $150 per half hour or any fraction thereof for cosmetic consultation; for time required regarding your services for any reason; consultation with other providers; review of records; or for bill collection. You agree to such charges to your payment method on file with no further notice.

Notice regarding appointment cancellation You agree to $50 charged to your payment method on file without further notice, if you do not provide 24 hour notice of cancellation or arrive more than 15 minutes late. If the service value is greater than $50, then you forfeit the service without refund. For frequent cancellations, we require a $50 deposit for appointments. You further agree that package sessions such as laser services, are scheduled 4-6 weeks apart, and failure to complete a session within 4-6 weeks, results in loss of that session or a $50 reinstatement fee. Free or promotional offers expire within 30 days, non-transferable, and are not rescheduled. We reserve the right to refuse or terminate service to disruptive persons without refund.

Advanced Beneficiary Notice- Medicare and or applicable insurances Medicare and or other insurance does not pay for all services, even some you and or your physician may deem medically necessary. Those below may not be covered benefits. This means you are responsible for payment and will be charged when service is rendered. Your signature is your request for these services when applicable. Medicare and other insurances have rules which change and or require interpretation. If the services are later covered, then your payment may be refunded upon request to us.

☐ Trip Fee: $25 M-F $50Weekend or out-of-area ☐ Other Service I am to pay when rendered:_____

☒ Further, I consent to tele-medicine and or chronic care management, or other services, which may not involve face to face encounters, without further notice and at M.D. discretion. Further, these are subject to Medicare or other insurance policies including patient payment responsibility. I may request a copy of each item. I may 'opt out' of such services by written 30 day notice.

Signature indicates the undersigned has had all questions answered and agrees to all notices.

Name:_____ **Sign:**_____ **Date:**_____