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 services or procedures ('treatments'), whether of a medically necessary and or cosmetic nature, which includes 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 treatment so that you may proceed or decline after considering the risks. This disclosure is to inform you about the risks, benefits, alternatives, side effects and possible complications 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 considered painless.
4. **Infection:** infection following treatment may require added treatments or antibiotics.
5. **Bleeding:** more than pinpoint bleeding is rare but occurs. Follow after-care instructions minimizes this and other risks.
6. **Allergic Reactions:** substances within or on skin, can induce severe allergic reaction that can occur with each successive treatment, whether medical, cosmetic, laser, or otherwise. Notify us of any tattoos, scars, or substances used on skin.
7. Brown/red darkening ('hyperpigmentation') or lightening ('hypopigmentation') of skin can occur anytime and be permanent.
8. Lasers can blind or harm eyes. I will wear issued eye protection during all applicable treatment.
9. Any treatment plan depends on my participation and providing full and accurate information at all times. Compliance with aftercare guidelines is crucial for healing and to prevent complications and is my responsibility as patient.
10. I agree 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 any 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 the service.

We often take photos or videos documenting, assessing, or 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 perform 'telemedicine' phone or video recorded services, or other audio or video documentation of any services without further notice. You agree 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 use is allowed during treatment 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 treatments, procedures, and services, that may be ordered and or performed by Reuben I Thaker MD PLLC, physician or non-physician personnel, on an ongoing basis. Regarding all treatments, procedures, services, 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 without refund.

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. We will provide a receipt you may submit to insurer, which may not reimburse you. All deposits are non-refundable.

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 or other records at any time to insurance companies, third party payers, authorized agents, credit card processors such as banks, or others reasonably related to payment of services; to claims review organizations; to insurance companies or designees; or to professional review organizations. My signature below indicates 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 retain your credit card information for future charges. Cosmetic service payment is due in full prior to service and is not covered by insurances. 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. All sales final.

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 listed.

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 #____________________________ Medical Emergency Contact Phone/name ____

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

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

☐Yes ☐No Are you now under the care of an M.D., dermatologist, 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 ☐Herpes ☐Cold sores ☐Any active infection ☐Accutane ☐Raised or keloid scars

☐Skin cancer/lesions/disease ☐Sunburn or tanning in past 2 wks ☐Darkened / lightened skin after trauma ☐Blood clots or bleeding disorder

☐Implanted medical device/pacemaker ☐Heart attack or stroke ☐Heart or lung disease or asthma ☐Seizures ☐Arthritis ☐Unexplained Hair loss

☐Recreational drugs [includes marijuana or alcoholism]__________________ ☐Tattoos: year and if professional/homemade: _________________

☐Anxiety or psychiatric condition ☐Attempting or now pregnant ☐Breastfeeding ☐Personal or family history of anesthesia problems

☐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 medical emergency, call 911. During a **national health crisis** or similar occurrence: you must follow our office safety instructions 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 without further notice.

Scope of Medical Service [non cosmetic services] Calls are answered during 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.

Terminating Services Any scheduled or recommended appointment that you miss, must be made up and completed within 30 days. If you do not, you agree we may consider the doctor-patient relationship, if any, to have been terminated by you, effective 30 days from the missed appointment. You further agree that we owe you no further services 30 days from a missed appointment, nor further notice of the termination of the doctor-patient relationship.

Notice regarding records You agree to keep a medication list with you at all times, to provide other medical facilities. You agree to request your records to be sent to us from any other health care sites you visit, during such visits, including medical offices, ER, hospitals, or similar. You further agree to assist us to obtain such records as needed. You may request and be provided a patient website portal, if applicable. 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 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. Frequent cancellations necessitate a $50 deposit for appointments. Free or promotional offers expire within 30 days, non-transferable. We reserve the right to refuse or terminate service to disruptive persons without refund.

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: Session 1 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. Reinstatement is $50 to resume service from a missed session at our discretion. If we judge you justifiably cannot finish a package, then used sessions are deducted at 200% of their package value, from any 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 necessary. 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 you may request us to refund your payment.
☒Further, I consent to tele-medicine and or chronic care management, or other services, which may not involve face to face encounters, at MD discretion and without further notice. Further, these may be subject to Medicare or other insurer policies including patient payment responsibility. I decline copies of each item unless I so state. I may 'opt out' of such services by written 30day notice.

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

Name:_______________________________________ **Sign:**____ **Date:**______________