Limited Patient Authorization for Disclosure of Protected Health Information
Please print all information. Form must be signed and dated.

Patient Name Printed:_____

Social Security Number: XXX-XX-_ _ _ _ **Date of Birth**:_____
Purpose of request (who will be authorized to receive information) – I authorize the practice to disclose or provide protected health information about me.
Who will provide or disclose information:

NoSweat Fort Wayne
5743 Wilkie Drive, Suite 1
Fort Wayne, IN 46804
Phone: (260) 413-5879

Who will be authorized to receive information (family, friends, others):

Name:_____Relationship:_____Phone: ( ) _____

Name:_____Relationship:_____Phone: ( ) _____

Name:_____Relationship:_____Phone: ( ) _____

Description of the information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

__All records, including every category listed below
__Office notes, labs and x-rays only
__office notes __lab results __x-rays; hospital
__other physicians records
__financial history report (previous 3 years only)
__only disclose the following: _____

Purpose of disclosure: (please check the purpose of the disclosure or check patient request):

__ Patient Request
__Other (please specify): _____

Expirations or termination of authorization: This authorization will expire upon the termination of your physician/patient relationship with NoSweat Fort Wayne, unless you specify an earlier termination. Your have the right to terminate this authorization at any time. Your must notify us in writing, if you decide to terminate the authorization prior to the normal expiration date.
Right to revoke or terminate: You have the right to revoke or terminate this authorization by submitting a written request.
Non-Conditioning statement: The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
Redisclosure: We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient signature _____ **Date** _____
You have the right to receive a copy of signed authorizations upon request.

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name_____ Today's Date_____

Date of Birth_____Age_____Occupation_____

Home Address_____ City_____ State__ Zip Code_____

Home Phone (___)_____Work Phone (____)_____

Email Address_____

Emergency Contact Name and Phone_____

How were you referred to us? _____

Reason for visit (area to be treated) _____

Prior treatment (if any) _____

Which of the following best describes your skin type? (Please circle one type number)

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

Do you regularly use tanning salons or sun bathe?_____How often?_____

MEDICAL HISTORY

Are you currently under the care of a physician? ❑Yes ❑ No
If yes, for what:_____

_____

Are you currently under the care of a dermatologist? ❑Yes ❑No
If yes, for what:_____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ❑Yes ❑No

Do you have any of the following medical conditions? (Please check all that apply)
❑Cancer ❑Diabetes ❑High blood pressure ❑Herpes ❑Arthritis
❑Frequent cold sores ❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions
❑Seizure disorder ❑Hepatitis ❑Hormone imbalance ❑Thyroid imbalance
❑Blood clotting abnormalities ❑Any active infection
Do you have any other health problems or medical conditions? Please list: _____
_____
Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) ❑Food ❑Latex ❑Aspirin ❑Lidocaine ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents ❑Others**:**_____
_____

MEDICATIONS
What oral medications are you presently taking? ❑Birth control pills ❑Hormones
❑Others (Please list): _____
Are you on any mood altering or anti-depression medication?_____
Have you ever used Accutane? ❑Yes ❑No, If yes, when did you last use it?_____
What topical medications or creams are you currently using? ❑ Retin-A® ❑Others (Please list):
_____

What herbal supplements do you use regularly?_____

HISTORY
Past Surgeries:_____
Medication Allergies:_____
Smoking: ❑Yes ❑No Packs/day: _____ Alcohol consumption: ❑Yes ❑No

Have you ever had laser hair removal? ❑Yes ❑No
Have you had any recent tanning or sun exposure that changed the color of your skin? ❑Yes ❑No
Have you recently used any self-tanning lotions or treatments? ❑Yes ❑No
Do you form thick or raised scars from cuts or burns? ❑Yes ❑No
Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❑Yes ❑No If yes, please describe: _____
_____

<u>For our female clients:</u>
Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No
Are you using contraception? ❑Yes ❑No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date:_____

NoSweat Fort Wayne

Disclosure and Consent for Opus Fractional Plasma treatments

1. **The Procedure**. I have requested that Dr Rettenmaier or his designated associate at NoSweat Fort Wayne perform the Opus Fractional Plasma treatment on the following areas of my body: _____
_____

2. Risks. There are risks related to the performance of this Procedure. I understand and acknowledge that the risks that may occur in connection with this procedure may include the following:

a. Discomfort and pain – I acknowledge that I will experience some discomfort during and after the Procedure.

b. Infection – Although rare, infection is a possibility any time a Procedure is performed. I acknowledge and understand that although even more rare, it is possible for an infection to become a blood-borne wide spread infection.

c. Blood clots in veins and lungs –Although extremely rare, it may be possible to develop a blood clot associated with this treatment that goes (embolizes) to the heart and/or lungs.

d. Allergic reactions – Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.

e. Bruising – Bruising in the treated area is possible, especially if, within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.

f. Painful or unattractive scarring – Scarring is a rare complication of Fractional Plasma assisted treatment, but scarring is possible because the skin surface is disrupted by the treatment. To minimize the chances of scarring, it is most important that I follow all postoperative instructions carefully.

g. Pigment changes (skin color) – During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.

h. Poor healing – The resultant open wound may require more than the usual one to three weeks to heal.

3. Contraindications. I acknowledge that I have been informed of certain conditions that must be met for me to have the Procedure performed, some of which are:

a. Pregnancy. I am not pregnant.

b. Age. I am 18 years old or older.

c. Oral Antiviral Agents. If I have a history of Herpes, Cold Sores or Fever Blisters, I have taken prophylactic oral antiviral agents for the prevention of Herpes Simplex Virus outbreak.

d. Other. I have had other contraindications, warnings and precautions explained to me by the Clinic and I agree that none of the contraindications apply to me and I agree to comply with all such warnings and precautions.

4. No Guarantee of Success. I recognize that this Procedure is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the results that will be achieved. It is possible that multiple Procedures may be required and that even then success may not be achieved.

5. Consent to Photography. For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from NoSweat Fort Wayne, I hereby grant permission to take photographs of myself, for medical records documentation and to publish those photographs for any lawful purpose, including, but not limited to, their website, social media accounts, and promotional materials, either digital or in print, in perpetuity.

By signing and dating this document I authorize Dr. Rettenmaier to edit, alter, share, remix, tweak, build upon or in any way alter the photograph(s) mentioned above. I also waive any rights of privacy or compensation associated with the use of my photographs for the personal or commercial purposes outlined above.

I have been given an opportunity to ask questions about my condition, alternate forms of anesthesia [if applicable] and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all the disclosures referred to herein. [I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment. I voluntarily consent and authorize that this Procedure to be performed by Dr Rettenmaier or his designated staff member.

_____	_____
Signature of Patient	Physician (Provider)
_____	_____
Print Name of Patient	Print Name of Physician or Provider
Date _____	Date _____

Opus RF Pixel Treatment Form

Name: _____
Date: _____

Physician: __**Philip A. Rettenmaier, D.O.**_____
Operator: _____

Medical History Completed: Yes ☐ No ☐ Consent Signed: Yes ☐ No ☐

Photos Taken: Yes ☐ No ☐ Smoke Evacuator used: Yes ☐ No ☐

Procedure: _____

Area Treated: Face ☐ Neck ☐ Abdomen ☐ Other: _____

RF Pixel: In-Motion (Glide Roller Tip) ☐ OR Stationary Tip ☐

Date of Tx	Skin Type	Energy (W)	Exposure Time (sec)...	.Plasma Intensity%	# of Passes

Notes:

_____

_____

_____