VERONA SPINE & WELLNESS CENTER

Red Light Therapy Skin Tightening

Client Forms & Office Policies

80 Pompton Ave., Third Floor | Verona, NJ 07044
973-857-1119 | www.veronaspine.com

Client Information

Please complete all fields. This information is kept strictly confidential.

First Name | **Last Name** | **Date of Birth**

Address | **City**

State | **Zip Code** | **Phone Number**

Email Address | **Occupation**

EMERGENCY CONTACT

Emergency Contact Name | **Relationship** | **Phone Number**

Health History Questionnaire

Please check all that apply. This helps ensure your safety during treatment.

If you have any of the conditions below, please inform your provider before treatment begins. Some conditions may require physician clearance or protocol modifications.

MEDICAL CONDITIONS

- ☐ Pregnant or breastfeeding
- ☐ Epilepsy or seizure disorder
- ☐ Undergoing chemotherapy or radiation
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Open wounds in treatment area
- ☐ Cold sores / herpes simplex
- ☐ Eczema
- ☐ Lupus
- ☐ Recent surgery (within 6 weeks)
- ☐ Pacemaker or implanted medical device
- ☐ Cancer (current or previous)
- ☐ Autoimmune disease
- ☐ Heart disease
- ☐ Blood clotting disorder
- ☐ Active skin infection
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Photosensitivity
- ☐ Other medical condition

RECENT TREATMENTS & MEDICATIONS

- ☐ Cosmetic injections within 2 weeks
- ☐ Chemical peel within 2 weeks
- ☐ Accutane within the past 6 months
- ☐ Blood thinning medication
- ☐ Laser treatment within 4 weeks
- ☐ Microneedling within 4 weeks
- ☐ Prescription retinoids
- ☐ Steroids (oral or topical)

Primary Physician

Current Medications (list all)

Known Allergies

Client Goals

Help us understand what you'd like to achieve so we can personalize your treatment plan.

AREAS TO BE TREATED

Please check all areas you would like treated:

- ☐ Face
- ☐ Neck / Decolletage
- ☐ Chest
- ☐ Abdomen
- ☐ Arms (upper)
- ☐ Hands
- ☐ Legs
- ☐ Thighs (inner)
- ☐ Thighs (outer)
- ☐ Buttocks
- ☐ Back
- ☐ Other

PRIMARY GOALS

Please check all that apply:

- ☐ Skin Tightening
- ☐ Fine Lines
- ☐ Wrinkles
- ☐ Skin Texture Improvement
- ☐ Acne Support
- ☐ Scarring
- ☐ Collagen Support
- ☐ General Skin Rejuvenation
- ☐ Weight Loss Support
- ☐ Body Contouring

ADDITIONAL INFORMATION

Describe your main skin concern in your own words (optional)

How long have you had this concern?

Any upcoming events / deadlines?

Informed Consent

Please read carefully before signing.

Red Light Therapy utilizes low-level red and near infrared light intended to support normal cellular function and improve the appearance of skin. This treatment is cosmetic and is not intended to diagnose, treat, cure, or prevent disease.

BY SIGNING BELOW, I UNDERSTAND AND AGREE THAT:

- **Results vary.**
  Individual outcomes depend on skin type, condition severity, lifestyle, and number of sessions completed.
- **Multiple treatments are generally necessary.**
  A series of sessions is typically required to achieve optimal results.
- **Improvement occurs gradually.**
  Results may continue to develop for several weeks after completing a treatment series.
- **Individual healing varies.**
  Your response to treatment may differ from others based on your unique physiology.
- **I have disclosed my medical history truthfully.**
  I understand that withholding relevant health information may affect my safety and results.
- **I may discontinue treatment at any time.**
  I am free to stop treatment at any point without penalty.

POTENTIAL TEMPORARY SIDE EFFECTS MAY INCLUDE:

☐ Mild redness ☐ Warm sensation ☐ Temporary skin sensitivity ☐ Dryness

Client Signature **Date**

Provider Signature **Date**

HIPAA Acknowledgement

Notice of Privacy Practices

> We are required by law to maintain the privacy of your protected health information and to provide you with this notice of our legal duties and privacy practices.

I acknowledge that I have received the Notice of Privacy Practices for Verona Spine & Wellness Center. I understand that this practice may use and disclose my health information for treatment, payment, and healthcare operations as described in the Notice.

Client Signature _____ **Date** _____

Photography Consent

Photographs help document your treatment progress and results.

Please initial your authorization below. You may select one or more options.

_____ I authorize photographs for my confidential medical record only.

_____ I authorize before and after photographs for educational and training purposes.

_____ I authorize photographs for marketing purposes including website, brochures, and social media.

I understand I may revoke authorization for future use at any time in writing.

Client Signature _____ **Date** _____

Financial Policy

Please review and sign to acknowledge our payment and refund policies.

Payment is due at the time of service.

ACCEPTED PAYMENT METHODS

☐ Cash ☐ Credit Card ☐ Debit Card ☐ HSA / FSA (where applicable)

REFUND POLICY

- Because aesthetic services are performed immediately, completed treatments are non-refundable.
- Unused prepaid sessions in a package may be subject to office policy and expiration terms.
- Gift certificates are non-refundable.

Client Signature **Date**

Cancellation Policy

We value your time and ask that you extend the same consideration to our providers.

- Appointments cancelled with less than 24 hours notice may incur a cancellation fee.
- No-shows may be charged up to 100% of the scheduled treatment fee.
- Late arrivals may require shortening or rescheduling the appointment at provider discretion.

Client Signature **Date**

By signing each section of this document I confirm that I have read, understand, and agree to all of the above policies and consent forms. I certify that the information I have provided is accurate and complete.