I hereby authorize Scott Hansen, ARNP or ECMA trained, certified staff to perform light based hair reduction on me. I understand that this procedure works on the growing hairs (anagen) and not on dormant hairs. I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I understand I may experience fewer, thinner, lighter, slower re-growth of hairs, temporary hair loss or permanent hair reduction. I understand that it is only effective on hair with color and does not treat white, grey, blond, or red hair. I understand that genetics, hormones, medication and hair color may interfere with hair loss and that I may not respond at all.

The procedure may result in the following adverse experiences or risks:

- **DISCOMFORT/PAIN** – Some discomfort and/or pain may be experienced during treatment.
- **REDNESS/SWELLING/BRUISING** – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.
- **HYPOPIGMENTATION / HYPERPIGMENTATION** (Changes in skin Color): During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- **WOUNDS** – Treatment can result in burning, blistering, or bleeding of the treated areas.
- **SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING** - May increase risk of side effects and adverse events.
- If any of these occur, please call our office.
- **INFECTION** – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office (206) 281-1616.
- **SCARRING** – Scarring is a rare occurrence, but it is possible. This can be further complicated if the skin surface is disrupted. To minimize the chances of scarring, it is important that you follow all post-treatment instructions provided by your healthcare staff.
- **PARADOXICAL HAIR GROWTH** – Stimulation of terminal hair growth following photo-epilation. Can occur within or adjacent to treated area.
- **LEUKOTRICHIA** - Temporary or permanent gray hair
- **EYE EXPOSURE** – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as electrolysis, waxing, plucking and depilatories
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Scott Hansen, ARNP and staff informed should I become pregnant during the course of treatment.

Photographic documentation may be taken. I hereby **do** not **authorize** the use of my photographs.

**ACKNOWLEDGMENT**

**BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR LIGHT BASED HAIR REMOVAL TREATMENT, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.**

<table>
<thead>
<tr>
<th>Signature-Patient or Guardian</th>
<th>Print Name/Relationship</th>
<th>Date</th>
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</thead>
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<thead>
<tr>
<th>Signature-Witness</th>
<th>Print Name</th>
<th>Date</th>
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<tbody>
<tr>
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</tbody>
</table>
PATIENT REGISTRATION FORM (LHR)

Today’s Date: __________________________

Name: ____________________________________________ Date of Birth: __________________________
(Last) (First) (M.I.)

Mobile phone: __________________________ Email: __________________________

Street address: __________________________________________________________

City: __________________________ State: __________ Zip: __________________________

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Gender: ☐ M ☐ F ☐ TG-MtF ☐ TG-FtM ☐ Non-Binary Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

<table>
<thead>
<tr>
<th>ALLERGIES</th>
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<tbody>
<tr>
<td>Name the Drug:</td>
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</table>

<table>
<thead>
<tr>
<th>SURGERIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
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</table>

<table>
<thead>
<tr>
<th>MEDICATION HISTORY</th>
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</thead>
<tbody>
<tr>
<td>Name the Drug</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICAL CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Acne</td>
</tr>
<tr>
<td>☐ Anxiety</td>
</tr>
<tr>
<td>☐ Cancer</td>
</tr>
<tr>
<td>☐ Depression</td>
</tr>
<tr>
<td>☐ Dermatitis</td>
</tr>
<tr>
<td>☐ Other:</td>
</tr>
</tbody>
</table>
Emerald City Medical Arts

Financial Policy

July 1, 2018

Patient Name: _________________________________

Thank you for choosing Emerald City Medical Arts. **Please carefully read and initial by each statement and sign below.**

This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality care for our clients. It is important that we work together to ensure that payment for services is as simple and straightforward as possible. Our practice manager or billing department will be glad to discuss these policies with you.

1. ______ I understand that if I am unable to make a scheduled appointment I need to contact Emerald City Medical Arts at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. **A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE, for a TOTAL $75 FEE ASSESSED for a NO CALL NO SHOW.**

2. ______ I understand that if I do not have my method of payment i.e. cash, credit, debit, or Care Credit, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

3. ______ I understand that Emerald City Medical Arts will collect all payments according to procedure schedules at the time of visit.

4. ______ I understand that a $25 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. NSF checks must be redeemed with certified funds (cashier’s check, money order, or cash.)

5. ______ I understand that if my account is not paid in full within 90 days of a statement date, a 35% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the Emerald City Medical Arts staff.

Signature of Responsible Party: ___________________________ Date: ______________

**ACKNOWLEDGEMENT of PRIVACY PRACTICES**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my medical provider’s *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my medical provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ___________________________
<table>
<thead>
<tr>
<th>Score</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the natural color of your hair?</strong></td>
<td>Sandy red</td>
<td>Blonde</td>
<td>Chestnut, Dark blonde</td>
<td>Dark brown</td>
<td>Black</td>
</tr>
<tr>
<td><strong>What is your eye color?</strong></td>
<td>Light blue, Gray</td>
<td>Blue, Gray, Green</td>
<td>Brown, Hazel</td>
<td>Dark Brown</td>
<td>Brownish black</td>
</tr>
<tr>
<td><strong>What is the color of sun unexposed skin areas?</strong></td>
<td>Reddish</td>
<td>Very pale</td>
<td>Pale with beige tint</td>
<td>Light brown</td>
<td>Dark brown</td>
</tr>
<tr>
<td><strong>How many freckles on unexposed skin areas?</strong></td>
<td>Many</td>
<td>Several</td>
<td>Few</td>
<td>Incidental</td>
<td>None</td>
</tr>
<tr>
<td><strong>What happens when you are in the sun too long without sunblock?</strong></td>
<td>Painful redness, blistering, peeling</td>
<td>Blistering followed by peeling</td>
<td>Burns, sometimes followed by peeling</td>
<td>Rarely burns</td>
<td>Never had a problem</td>
</tr>
<tr>
<td><strong>How well do you turn brown?</strong></td>
<td>Hardly or not at all</td>
<td>Light color tan</td>
<td>Reasonable tan</td>
<td>Tan very easily</td>
<td>Turn dark very quickly</td>
</tr>
<tr>
<td><strong>Do you turn brown within one day of sun exposure?</strong></td>
<td>Never</td>
<td>Seldom</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
<tr>
<td><strong>How does your face respond to the sun?</strong></td>
<td>Very sensitive</td>
<td>Sensitive</td>
<td>Normal</td>
<td>Very resistant</td>
<td>Never had a problem</td>
</tr>
<tr>
<td><strong>When did you last expose yourself to the sun or artificial sun treatments?</strong></td>
<td>More than 3 months ago</td>
<td>2-3 months ago</td>
<td>1-2 months ago</td>
<td>Less than 1 month ago</td>
<td>Less than 2 weeks ago</td>
</tr>
<tr>
<td><strong>Do you expose the area to be treated to the sun?</strong></td>
<td>Never</td>
<td>Hardly ever</td>
<td>Sometimes</td>
<td>Often</td>
<td>Always</td>
</tr>
</tbody>
</table>

**TOTAL**

___ 00 – 07 points = Skin type I  
___ 08 – 16 points = Skin type II  
___ 17 – 25 points = Skin type III  
___ 26 – 30 points = Skin type IV  
___ 31 – 40 points = Skin types V & VI
Recommended Pre & Post Care for Laser Hair Reduction Treatments
For best results please follow these instructions

Before your treatment:
- Hair should be shaved 24-48 hours before treatment
- Do not wear makeup or deodorant on the treated area the day of treatment
- No sun-tanning or self-tanners 4 weeks prior to treatment
  o Includes spray tans, tanning lotions, tanning beds, sun exposure, etc.
- Some medications and supplements may increase the risk of bruising.
- No waxing, plucking or tweezing at least 4 weeks prior to treatment
  o Some body parts may require a longer wait time
- Avoid treatments that may irritate the skin for 1-2 weeks prior to treatment (depilatories, harsh chemicals, etc.)
- Notify clinic with any changes to your health history or medications since your last appointment
- History of herpes or cold sores may require an anti-viral prescription prior to treatment
- You may use 4-5% topical lidocaine 30 minutes prior to treatment and/or up to 800mg ibuprofen to lessen discomfort during treatment if needed. Both medications are available without a prescription.

After your treatment:
- Avoid sun exposure and use a broad spectrum (UVA/UVB) sunscreen
- Redness and perifollicular edema (looks like a rash/bug bites) are common and resolve with time
- Bruising and swelling are less common but may occur and will resolve with time
- Hair may take up to 2 weeks to fall out
- Avoid heat – hot tubs, saunas, etc. for 1-2 days
- Avoid skin irritants (examples below) a few days post-treatment
  o Products containing tretinoin, retinol, benzoyl peroxide, glycolic/salicylic acids, astringents, etc.
- Do not wax or pluck between treatments
- Notify clinic of any concerns (blistering, excessive redness/swelling, etc.)
- Hair removal requires a series of treatments. The number of treatments depends on body location and type of hair.
- Additional instructions

_____________________________________________________________________

PLEASE KEEP THIS FORM.

16 Roy Street, Seattle WA 98109
(206) 281-1616