# THE REJUVENATION CLINIC
# PATIENT REGISTRATION

**Patient Information:**

Patient Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: (mm/dd/yy) _____/_____/_____ Age: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____

Email Address: _____

**Primary Care Doctor:** _____

**In Case of Emergency:** Name: _____

Relationship: _____

Phone: (_____)_____

**Permission to Treat:** I hereby give my permission to THE REJUVENATION CLINIC to administer treatment. To the best of my knowledge, the information provided to is complete and correct. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

Signature: _____ Date: _____

## The Rejuvenation Clinic

Services provided are cosmetic and/or services not covered by insurance. If you feel that your insurance company will cover the services provided, you may submit them to your insurance. All professional services rendered are charged to the patient and due at the time of service.

The patient is responsible for all FEES, regardless of insurance coverage. I agree that should this account be referred for collection, I will be responsible for all collection costs, attorney's fees and court costs. If there is a payment dispute, I waive my privacy protection under HIPAA. I have read and understand all of the above and have agreed to these statements.

Dr. Pettigrew reserves the right to refuse to perform treatments or surgery on anyone who is not deemed an appropriate candidate (whether physically, medically or psychologically).

Signature Date

Revised 5/18

# The Rejuvenation Clinic
## 600 E. 70th St Savannah, GA 31405

## PRIVACY POLICY

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO).

To that end, our practice and its physicians and staff will—
1. Adhere to the standards set forth in the Notice of Privacy Practices.
2. Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment life insurance applications, etc. without an authorization from the patient.
3. Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
4. Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its physicians and staff will: Implement reasonable measures to protect the integrity of all PHI maintained about patients.
5. Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
6. Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will: a. Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements. b. Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
7. Recognize that although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will— a. Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals. b. Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
8. All patients and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.
9. All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

## ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice, its physicians, and staff.

_____
Signature of Patient or Patient's Personal Representative

_____
Print Name of Patient or Patient's Personal Representative

_____
Date

# THE REJUVENATION CLINIC PATIENT MEDICAL HISTORY FORM

**PATIENT NAME**_____ **DATE**_____

| **ALLERGIES:** None ☐ |
|---|
| **Reaction** |
| |
| |
| |

| **MEDICATIONS (Prescribed, over the counter, supplements):** None ☐ | | |
|---|---|---|
| **Medication Name** | **Dose** | **Frequency** |
| | | |
| | | |
| | | |
| | | |

| **MAJOR SURGERIES:** None ☐ | **DATE** |
|---|---|
| | |
| | |
| | |

**PAST MEDICAL HISTORY:** None ☐

| | Personal | Family | | Personal | Family |
|---|---|---|---|---|---|
| ADD/ADHD | | | High Cholesterol | | |
| Alcohol Abuse | | | Insomnia | | |
| Anemia | | | Kidney Disease | | |
| Arthritis | | | Liver Disease | | |
| Asthma/COPD | | | Lung Disease | | |
| Bleeding Disorder | | | Migraines/Headaches | | |
| Cancer | | | Mood Swings | | |
| Constipation | | | Nervousness | | |
| Depression/Anxiety | | | Obesity | | |
| Diabetes Mellitus | | | Palpitations | | |
| Drug Abuse | | | Polycystic Ovarian Syndr. | | |
| Eating Disorder | | | Psychiatric Disorder | | |
| Fatigue | | | Rashes | | |
| GERD (Reflux) | | | Seizures (Epilepsy) | | |
| Glaucoma | | | Shortness of Breath | | |
| Heart Disease | | | Sleep Apnea | | |
| High Blood Pressure | | | Stroke | | |
| History of Diet Pill Use | | | Thyroid Disorder | | |

**Any additional IMPORTANT health information? Please explain:**

_____

_____

# THE REJUVENATION CLINIC PATIENT
# MEDICAL HISTORY FORM

Have you EVER had cold sores? YES or NO (if yes,you should take medication for BBL/Laser treatments) Have you ever had a keloid or thickened scar? YES or NO

Do you take any Aspirin products or blood thinners? YES or NO

Do you smoke? NO or YES: how much?:_____

How much alcohol do you drink per day :_____

## (***This section is optional) WOMENS HEALTH and SEXUAL WELLNESS :

Have you had a hysterectomy? YES or NO If no, when was your last pap smear?_____

Are you UnHappy with Appearance of Vagina/Labia ? YES or NO

How many vaginal deliveries?_____ How many c-sections?_____

Please rank in order of concern. (0 = no problem at all, 4 = bothers you the most)

_____Painful Sex

_____Vaginal Dryness

_____Vaginal Looseness or decreased feeling

_____Leaking Urine

Do you have a decreased sex drive? NO or YES

If yes, when was the last time you had a normal sex drive?_____

Do you have trouble having orgasms? YES or NO

Interested in getting information about The O-SHOT or diVa Vaginal Laser or Labiaplasty ? Yes / No

Are there any specific sexual problems that you would like to discuss?_____

_____

_____

Patient Name_____

Date:_____

The Rejuvenation Clinic

# Fitzpatrick's Skin Type Chart

| Skin Score | | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| | What is your eye color? | Light Blue or Grey | Blue or Green | Hazel or Light Brown | Dark Brown | Brownish Black |
| | What is your natural hair color? | Red, Sandy Red | Blonde | Dark Blonde, Chestnut, Brown | Dark Brown | Black |
| | What is the color of your skin (unexposed areas)? | Reddish | Very Pale | Pale with Beige Tint | Light Brown | Dark Brown |
| | Do you have freckles on exposed areas? | Many | Several | Few | Incidental | None |
| | What happens when you stay in the sun too long? | Painful, redness, blistering and peeling | Blistering followed by peeling | Burns, sometimes followed by peeling | Rarely Burn | Never burn |
| | To what degree do you turn brown? | Hardly or not at all | Light tan | Reasonable Tan | Tan very easily | Turn dark brown quickly |
| | How does your face respond to the sun? | Very sensitive | Sensitive | Normal | Very resistant | Never has problems in the sun |
| | When did you last expose yourself to the sun, tanning beds or self-tanning creams? | More than 3 months ago | 2-3 Months | 1-2 Months | Less than 1 month ago | Less than 2 weeks ago |
| | How often is the area that you want to have treated exposed to the sun? | Never | Hardly Ever | Sometimes | Often | Always |
| **TOTAL:** | **Score:** 0-7<br>8-16<br>17-25<br>26-30<br>Over 30 | | **Skin Type:** I<br>II<br>III<br>IV<br>V-VI | | | |