The Spa at Yarrow Bay

(Phone) 425-822-0300 (Fax) 425-822-4999

Today's Date: ____/_____/_____

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

Date of Birth: ____/____/_____

Address:_____

(Street) (Unit/Apt#)

_____.

(City) (State) (Zip)

Gender (please circle): M/F Marital Status (please circle): S/M/D/P/W/Other

Phone Number:_____ Cell Number:_____

Emergency Contact:_____

Phone:_____Relationship:_____

Email Address: _____

Would you like to receive spa specials via email? Yes or No

Referred By:_____

Allergies:

Drug: _____ Reaction(s): _____

_____ _____

_____ _____

Latex Allergy: (Y)____ (N)____ Environmental:_____

Medical History

Have you ever had the following? (Please circle ANY that apply)

- Heart Disease / Heart Murmur
- Mitral Valve Prolapse
- High Blood Pressure
- Bleeding Tendencies
- Lupus or Autoimmune Disease
- Blood Clot (you or family member)
- Blood Clotting Disorder (you or family member)
- Hepatitis / HIV
- Anemia
- Herpes (cold sore, genital or shingles
- Diabetes
- Acid Reflux Disease
- Asthma
- Sleep Apnea / Snoring
- Migraines / Headaches
- Stroke / TIA
- Psychiatric Care
- Arthritis
- Cancer (of _____
- (Females) History of miscarriage

Have you recently had?
(Please circle ANY that apply)

- Fever, chills, nausea, vomiting, diarrhea
- Skin rashes, lumps
- Frequent colds, sinus congestion
- Taken blood thinners, When? _____
- Anxiety, depression
- Changes in vision, hearing
- Sore throat, bleeding gums
- Lumps in neck
- Breast masses, nipple discharge
- Chest pain, shortness of breath, difficulty breathing
- Heartburn, abdominal pain
- Numbness/tingling/cramping in hands and/or feet
- Swelling of hands and/or feet
- Seizures, paralysis

Previous Surgeries / Hospitalizations and Date:

_____

_____

_____

_____

Current Medications:

_____

_____

_____

_____

Social History:

Use of tobacco:

____ I am a non-smoker who has never used tobacco products.
____ I am a former smoker who quit _____ months/years ago.
____ I am a current smoker and I smoke _____ cigarettes/packs per day.

Type of employment: _____

Would you be interested in information on any of the following? Please Circle.

- Laser tattoo removal
- Laser skin resurfacing
- Cosmetic Surgery
- Botox/Injectables
- Spa services

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We kindly ask for a 48 hour notice to cancel or reschedule all spa or laser service appointments. Without proper notice, cancellation penalties will apply

I hereby declare that the information I have provided on this form is a true and accurate record to the best of my knowledge. I declare I will inform my Master Aesthetician of any important changes in my health and/or medications.

_____ _____

Patient Signature Date

The following line is to be signed by your Master Aesthetician.

_____ _____

Reviewed by Date

The SPA at YARROW BAY

Facial Registration & Consent for Services

Name: _____Date: _____

What is your skin type?

- ☐ Normal
- ☐ Combination
- ☐ Sensitive
- ☐ Dry
- ☐ Acne
- ☐ Very Sensitive/Rosacea
- ☐ Oily
- ☐ Mature

Do you suffer from any allergies? (cosmetic ingredients, food, iodine, medications, hay fever, latex, etc.)

_____

Please list any medications/supplements you're currently taking: _____

_____

Have you ever used Accutane? If yes, please explain _____

What skincare products are you currently using? AM: _____

PM: _____

How often do you receive a facial? ☐ Regularly ☐ Seldom ☐ Never

What are your present skincare concerns? _____

_____

Have you recently received any of the following spa services?

☐ Laser Treatments ☐ Peels ☐ Facials ☐ Botox/Fillers/Other

If yes, what/when? _____

_____

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge.

I understand that some treatments may be more aggressive in nature and will follow the post care treatment protocol recommended by the Aesthetician. I understand that some skin conditions may require more than one treatment and home care products to achieve the desired results.. Results cannot be guaranteed due to individual skin type(s) and condition(s).

Client Signature: _____Date: _____

YARROW BAY
PLASTIC SURGERY

COVID-19 INFORMED CONSENT AGREEMENT

☐ I, the undersigned patient, consent to an in-person consultation and/or to have my Doctor and/or his/her staff (hereinafter collectively "my Doctor") perform medical procedures, whether regarded as necessary, elective or aesthetic, during the time of the COVID-19 pandemic and after. I understand in-person consultations and/or having my procedure performed at this time, despite my own efforts and those of my Doctor, may increase the risk of my exposure to COVID-19. I am aware that exposure to COVID-19 can result in severe illness, intensive therapies, extended intubation and/or ventilator support, life-altering changes to my health, and even death. I am also aware of the possibility that the procedure itself, whether performed in my Doctor's office or in a hospital, may result in a more severe case of COVID-19 than I might have had without the procedure.

☐ I also understand in-person consultations and/or having my procedure performed at this time increases the risk of my transmission of COVID-19 to my Doctor. This virus has a long incubation period, there may be as yet unknown aspects of its transmission, and I realize that I may be contagious, whether or not I have been tested or have symptoms. To reduce the possibility of COVID-19 exposure or transmission at my Doctor's office, I accept that my Doctor will implement infection-control procedures with which I must comply, before, during and after my consultation and/or procedure, for my own protection as well as that of my Doctor. I understand my cooperation is mandatory, whether or not I personally feel such COVID-19 procedures and/or preventive measures are necessary.

☐ I have informed my Doctor of any COVID-19 testing I or any person living with me during the past 14 days has received, as well as the results of that testing, and if I am tested between now and the date of my procedure, I will immediately provide the results of that testing to my Doctor. I understand my Doctor may require that I be tested, possibly at my own expense and regardless of any prior testing, and that the results of that testing must be satisfactory to my Doctor, before I may receive my procedure.

☐ I confirm neither I nor any individual living with me has any of the COVID-19 symptoms listed by the Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID19-symptoms.pdf, which website I have consulted; neither I nor any individual living with me during the past 14 days has experienced any such symptoms; and that I and all persons living with me for the past 14 days have practiced all personal hygiene, social distancing and other COVID-19 recommendations contained within all governmental orders issued by my city and state. I understand I must honestly disclose this information to avoid putting myself and others at risk.

☐ All topics above have been discussed with me, and all my questions have been answered to my satisfaction. Being fully informed, I accept the risk of COVID-19 exposure and I will bear the cost of any COVID-19 treatments required. I have been given the opportunity to postpone my in-person consultation and/or procedure until the COVID-19 pandemic is less prevalent, but I choose to have my in-person consultation and/or procedure performed now. If I am the parent, guardian or conservator of the patient, I hold his/her health care power of attorney. I have read this COVID-19 Informed Consent Agreement and am authorized to consent on the patient's behalf.

☐ _____ _____
Patient/Authorized Representative Signature and Initials Print Name & Date **[First encounter]**

☐ _____ _____
Patient/Authorized Representative Signature and Initials Print Name & Date **[Day of procedure]**

Yarrow Bay Plastic Surgery
5209 Lake Washington Blvd. Suite 115, Kirkland, WA 98033
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PLASTIC SURGERY

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical information is used for diagnosis, consultation treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient
Initials

_____ I understand that telehealth involves the communication of my medical information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Washington at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include, but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that Skype, FaceTime, Zoom, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he/she is my healthcare provider.

_____ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

_____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

_____ I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between Dr. Sarah McMillan, Dr. Daniel Liebertz, Yarrow Bay Plastic Surgery staff and _____
(Patient's name)

_____ _____
Patient or Legal Representative Signature/Date/Time Relationship to Patient

_____ _____
Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have I have answered all questions fully, and I believe the patient/patient's legal representative fully understands what I have explained.

_____
Healthcare Provider Signature/Date/Time

_____ Copy given to patient _____ Original in chart

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