DIAMOND GLOW®

PATIENT CONSENT FORM

DiamondGlow® is a next-level skin-resurfacing technology that simultaneously exfoliates and extracts, while infusing skin with targeted serums to address specific skin quality concerns.

Please review and initial the following statements prior to your DiamondGlow® treatment:

____ I acknowledge that I might experience a scratchy, stinging sensation during the treatment. This sensation will subside during the post-treatment protocol shortly after the treatment is finished.

____ I understand that if I fail to use sunscreen, I am more susceptible to sunburn and hyperpigmentation.

____ I acknowledge that I have not been on medication for acne therapy during the past 6 months.

____ I acknowledge that I have not been using retinoids or any other exfoliating products for the past 3 days and I will discontinue the use of retinoids for 1 to 3 days after the procedure.

____ I acknowledge that facial telangiectasia (small blood vessels) is sometimes more apparent immediately after the treatment, when the skin is thin, and will diminish after my skin has recovered from the treatment.

____ I agree to remove my contact lenses prior to the procedure (if applicable).

____ I have informed my skincare specialist that I am prone to cold sores and I am currently not experiencing an outbreak. I acknowledge that any area around the mouth or face that is prone to cold sores will be avoided during the treatment (if applicable).

____ I have informed my skincare specialist of potential allergies to nickel.

Uses
The DiamondGlow® device is a general dermabrasion device that gently removes the top layer of skin and delivers topical cosmetic serums onto the skin.

Please see back page for Important Safety Information and the SkinMedica® Pro-Infusion Serums Disclaimer.

____ I understand that the skincare specialist performing the treatment uses tools that are either disinfected or disposable.

____ I acknowledge that my skin may experience temporary tightness, mild erythema (redness), or slight swelling, which should dissipate in a few hours following the treatment.

____ I understand if I am **pregnant** or **lactating**, have **rosacea**, **salicylate/aspirin sensitivity**, or an outbreak of any skin condition, I should consult with my physician prior to receiving the DiamondGlow® treatment.

I hereby agree to have the DiamondGlow® treatment performed on my skin by a trained operator and to follow all post-treatment protocols.

Print name: _____ **Date:** _____

Signature: _____ **Date:** _____

DIAMOND GLOW®

Important Safety Information
The DiamondGlow® treatment is not for everyone. You should not have a DiamondGlow® treatment if you have compromised skin quality. Tell your provider if you are pregnant or lactating, or if you have any medical conditions, including allergies, and if you are using topical medications on the area to be treated.

Typical side effects include a scratchy, stinging sensation during the treatment and temporary tightness, redness or slight swelling after the treatment. Rare serious side effects may also occur and include severe skin irritation and allergic reactions.

SkinMedica® Pro-Infusion Serums Disclaimer
SkinMedica® Pro-Infusion Serums are intended to meet the FDA's definition of a cosmetic product, an article applied to the human body to cleanse, beautify, promote attractiveness, and alter appearances. These products are not intended to be drugs that diagnose, treat, cure, or prevent any disease or condition. These products have not been approved by the FDA and the statements have not been evaluated by the FDA.

Please talk to your provider for additional information.

Allergan Aesthetics
an AbbVie company

DIAMOND GLOW™

Diamond Glow Questionnaire

1. Are you currently pregnant and/or breastfeeding?
   YES or NO
2. What was the date of your last period? _____
3. Would you consider yourself to have dry, oily, or combination skin?
   _____
4. Would you consider yourself to have normal or sensitive skin?_____
5. Do you have a skincare routine? What skincare products do you currently use?_____
   _____
6. What do you see when you look in the mirror? What are some concerns you want to address with this treatment? What are some goals you have for your skin?
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____

Paragon Physical Medicine/Chaffee Chiropractic Clinic Inc
242 E Milltown Rd, Wooster, OH 44691, (330)345-4440

PATIENT INFORMATION

First Name_____ MI___ Last Name_____ Date_____/_____/_____

Address_____City_____ST_____Zip_____

Home Phone#_____Work#_____Cell#_____

Email_____ Social Security_____

Birth Date_____/_____/_____ Age_____ Gender: Male Female

Family Physician and Clinic: _____

Do we have permission to discuss this case with another family member Y or N Whom: _____
Whom may we thank for referring you to our office_____

Person financially responsible for this account _____

Spouse_____ Your Employer_____

Phone#_____ Phone#_____

Address_____ Address_____

_____ _____

DOB_____SS#_____ Emergency Contact_____

Place of Emp_____ Relation & Phone#_____

Email_____

INSURANCE INFORMATION

Ins. Co. Name_____
Policy#:_____
Group#:_____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's SS#:_____
Insured Add:_____
_____

Employer of Insured:_____

Secondary Ins._____
Policy#:_____
Group#:_____
Subscriber's Name: _____
Subscriber's Birth Date: _____
Subscriber's SS #:_____
Insured Add:_____
_____

Employer of Insured:_____

Paragon Physical Medicine/Chaffee Chiropractic Clinic Inc
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Wooster, Ohio 44691
(330) 345-4440

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures: We will use and disclose elements of your Protected Health Information (PHI) in the following ways:

Without your signed authorization
Chiropractic treatment
Payment (cash, insurance, worker's compensation, personal injury)
When release is required by law, including in judicial settings and to health oversight regulatory agency and law enforcement
In emergency situations or to avert serious health/safety situations
To medical examiners, coroner or funeral directors to aid in identifying you or to help them in performing their duties.

Special Cases

To contact you about appointment reminders, treatment alternatives and other health related benefits and services

Other

All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your Rights

Restrictions: To request restricted access to all or part of the PHI, write specific information on your patient information and contact our insurance department. We are not required to grant your request.
Confidential Communication: To receive correspondence of confidential information by alternate means or location, contact our insurance or front desk department.
Access: To inspect or receive copies of your PHI, you must sign a consent form.
Amendments: To request changes made to your PHI, contact our insurance department. We are not required to grant your request.
Accounting: To receive an accounting of the disclosures by us of your PHI in the six years prior to your request, contact our insurance department.
This Notice: To get updates or reissue of this notice, contact our front desk department.
Complaints: Complaints to Paragon Physical Medicine/Chaffee Chiropractic Clinic Inc or the U.S. Department of Health & Human Services. If you feel your privacy rights have been violated, register your complaint in writing to Dr. Bryce Chaffee. The law forbids us from taking retaliatory action against you if you complain.

Our Duties

We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update of this notice.

Privacy Contact: For more information about our privacy practices, please contact this clinic at:

PPM/Chaffee Chiropractic Clinic Inc, 242 East Milltown Road, Wooster, Ohio 44691, (330) 345-4440
Effective date: April 14, 2003

I acknowledge receipt of this notice:

_____	_____	_____/_____/_____	_____/_____/____
Patient or Authorized Signature	**Printed Name**	**DOB**	**Date**

If you are signing as the patient's representative:

_____	_____
Patient's Printed Name	Relationship to Patient

ASSIGNMENT OF HEALTH PLAN BENEFITS AND RIGHTS
AS WELL AS AN
APPOINTMENT AND/OR DESIGNATION AS MY PERSONAL REPRESENTATIVE AND AN ERISA/PPACA REPRESENTATIVE AND BENEFICIARY

I understand and agree that (regardless of whatever health insurance or medical benefits I have), I am ultimately responsible to pay **Paragon Physical Medicine/CHAFFEE CHIROPRACTIC CLINIC INC, DR BRYCE CHAFFEE, DR TAMI CHAFFEE, CHRISTINA COOK, CNP** as well as all employees, employers, representatives, and agents thereof, (hereinafter collectively referred to as "Healthcare Provider") the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that ***have been*** **or** ***will be*** rendered or provided; as well as designating and appointing Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under. I hereby authorize the release of any health status, conditions, symptoms or treatment information contained in your records that is needed to file and process insurance or medical plan claims, to pursue appeals on any denied or partially paid claims, for legal pursuit as to any unpaid or partially paid claims, or to pursue any other remedies necessary in connection with same. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including, but not limited to, any ERISA governed plan/insurance contract, PPACA governed plan/insurance contract) rights that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies). I also hereby appoint and designate that Healthcare Provider can act on my/our behalf, as my/our Personal Representative, ERISA Representative, and PPACA Representative as to any claim determination, to request any relevant claim or plan information from the applicable health plan or insurer, to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider, and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Provider is my/our beneficiary regarding my/our health plan as contemplated by both ERISA and PPACA, and that Healthcare Provider can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan. This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, test, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan or this document is to be considered as valid and as enforceable as the original.

Signed this _____ day of _____, 20 ____. X_____ DOB_____/_____/_____
(patient signature)

X_____
(signature of Guardian if applicable)

X_____
(please print patient name)