CONSENT FORM FOR SKINMEDICA® PEEL

SkinMedica
An Allergan Company

☐ Illuminize Peel® ☐ Vitalize Peel® ☐ Rejuvenize Peel™

PURPOSE: Helps to improve the texture and appearance of your skin.

PATIENTS WHO SHOULD NOT BE TREATED:

- Patients with active cold sores or warts, skin with open wounds, sunburn, excessively sensitive skin, dermatitis or inflammatory rosacea in the area to be treated. Inform the esthetician if you have any history of herpes simplex
- Patients with a history of allergies (especially allergies to salicylates like aspirin), rashes, or other skin reactions, or those who may be sensitive to any of the components in this treatment
- Patients who have taken *Accutane*® (isotretinoin) within the past year
- Patients who are pregnant or breastfeeding (lactating)
- Patients who have recently received chemotherapy or radiation therapy
- Patients with vitiligo
- Patients with a history of an autoimmune disease (such as rheumatoid arthritis, psoriasis, lupus, multiple sclerosis, etc.) or any condition that may weaken their immune system

Note: *Patients who have had medical cosmetic facial treatments or procedures (e.g. laser therapy, surgical procedures, cosmetic filler, microdermabrasion, etc) should wait until skin sensitivity completely resolves before receiving a SkinMedica® Peel.*

Patients who have had cosmetic injections should wait until full effect of their treatment is seen before receiving a SkinMedica® Peel.

ONE WEEK BEFORE YOUR SKINMEDICA® PEEL, AVOID THESE PRODUCTS AND/OR PROCEDURES:

- Electrolysis
- Waxing
- Depilatory Creams
- Laser Hair Removal

THREE DAYS BEFORE YOUR SKINMEDICA® PEEL, AVOID THESE PRODUCTS AND/OR PROCEDURES:

- *Retin-A*, *Renova*®, *Differin*®, Tazorac®
- Any products containing retinol, alpha-hydroxy acid (AHA) or beta-hydroxy acid (BHA), or benzoyl peroxide
- Any exfoliating products that may be drying or irritating

Note: *The use of these products/treatments prior to your peel may increase skin sensitivity and cause a stronger reaction.*

ADVERSE EXPERIENCES THAT MAY OCCUR AFTER YOUR SKINMEDICA® PEEL:

It is common and expected that your skin will be red, dry, possibly itchy and/or irritated. It is also possible that other adverse experiences (side effects) may occur. Although rare, the following adverse experiences have been reported by patients after having a SkinMedica® Peel: skin breakout or acne, rash, swelling, redness and burning. ***Call the office immediately if you have any unexpected problems after the procedure.***

PLEASE READ AND INITIAL THE FOLLOWING:

I do not have any of the conditions described in the "Patients Who Should Not Be Treated" section _____
I understand that the actual degree of improvement cannot be predicted or guaranteed _____
I understand that the amount of visible peeling cannot be predicted or guaranteed _____
I understand that I may need several of these peels to achieve optimal results _____
I understand that for optimum results the post-peel instructions must be followed _____

For Vitalize Peel® or Rejuvenize Peel™ only: I understand that I may have from 2 to 5 days of downtime _____

By my signature below, I acknowledge that I have read this consent form and understand it. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction. I have been adequately informed of the risks and benefits of this treatment and wish to proceed with this SkinMedica® Peel.

Patient Signature	**Print Name**	**Date**
Witness Signature	**Print Name**	**Date**

Please make a copy of completed and signed consent form. Place one copy in patient's file and give one copy to patient to take home.

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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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)