Vitality Medspa

- **Please arrive 15 minutes prior to your appointment** so that you have time to complete any necessary paperwork and/or prepare for any procedure you are receiving.

- **Cancellation/Rescheduling Policy:** We ask that appointments be guaranteed against late cancellation or rescheduling with a major credit card. Please provide at least 24 hours' notice if you need to reschedule or cancel an appointment. This allows us enough time to fill appointments. Late cancellations and "no-shows" will be charged a fee according to our cancellation policy listed on the following page.

- **Quiet Please:** Please turn off cell phones on arrival and speak softly. We strive to maintain a tranquil and stress-reducing experience for all our guests.

- **Children:** To maintain our serene atmosphere and allow for procedures to be performed without interruption, we ask that you not bring children with you to your appointment.

- **Forms of Payment:** We accept credit cards, debit cards, and cash. Personal checks are not accepted.

I have read and understand the above policies. I agree to always abide by these policies while at Vitality Medspa.

Print Name_____Date_____

Signature_____

Vitality Medspa does not discriminate on basis of race, color, national or ethnic origin, ancestry, age, marital status, religion or religious creed, disability or handicap, sex, gender, or gender identity and/or expression including a transgender identity, sexual orientation, military or veteran status.

Vitality Medspa

Preferred Name :_____ Preferred Pronouns _____

Gender Assigned at Birth _____ Gender Identitity _____ Sexual Orientation _____

Date of Birth: _____ DL or SS# _____ Age _____

Address: _____ Zip Code _____

Phone: _____ Email _____

Emergency Contact Name: _____ Phone _____ Relationship _____

Pharmacy Number _____ Current Physician _____

History of Allergies Y N Known Allergies _____

Are you pregnant or lactating? Y N

Circle any of the following illnesses you have, have had in the past, or have a family history of:

Myasthenia Gravis Hepatitis Eye Disease Autoimmune Disease ALS

Numbness Vision Problems Muscle Weakness Easton Lambert Disorder

Are you currently taking Aminoglycosides or any other antibacterial medications to treat bacterial infections? Y N

If yes, please explain: _____

Previous Hospitalizations/Operations _____

- I understand that I am responsible for any and all cost related to lab tests performed by outside parties.
- I understand that insurance may not cover the cost of lab tests ordered by Dr. Michelle Mendoza.
- I understand that Dr. Michelle Mendoza does not accept insurance, will not bill my insurance for me, and cannot guarantee that I will be reimbursed by my insurance company.
- I understand that any billing issues related to lab work must be directed to the lab performing the tests and my insurance company.
- I understand that requests for any records may take up to 3 business days to process and must be made in writing.
- I have read and understand the late cancellation/'no-show' policy.
- I understand that any prescriptions or supplies (including BHRT pellets, topicals, and injectables) ordered for me require a deposit and will not be refundable. This amount will vary by medication and/or procedure.
- I understand that any dermal filler cannot be used after 30 days of the initial appointment and I am responsible for making and coming to my follow up appointments.

I understand that the information on this form is essential to determine my medical and cosmetic needs and the provisions of treatment. I understand that is any changes occur in my medical history or health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all the answers have been recorded truthfully and will not hold any staff member responsible for errors or omissions that I have made in the completions of this from.

Print _____

Sign _____ Date _____

- **Compliance Agreement**

All patients must comply with physician orders for lab work as well as all follow up visits. Patients who are out of compliance will be ineligible to receive treatment and/or prescription refills.

- **Refill Requests**

Patients who have not been seen in office in more than six months are not eligible for medication refills.

- **Photo Release**

I, _____(print name) authorize Vitality Medspa staff to take photographs.

I **DO** **DO NOT** authorize Vitality Medspa to use my photographs.
(Please choose one)

These photos may be used in promotional material, for patient education, on our website or social networks, or in our photo album. I understand that I have the right to decline and will notify staff if I do not wish for my photos to be used.

Print Name_____

Patient Signature_____Date_____

- **Cancellation Policy**

We require a credit card in order to reserve an appointment. We require 24 hours' notice to cancel or reschedule an appointment. If you cancel or reschedule your appointment with less than 24 hours notice, we reserve the right to charge a fee of $30.00. No-show's are included under this policy. If you arrive late for an appointment the end time remains the same as originally scheduled. Please be aware that if you are more than 15 minutes late for your appointment, we may not be able to provide the service for which you have been scheduled and a cancellation fee will apply.

Print_____

Sign_____Date_____

Dr Mendoza does not accept gratuity. If you would like to show your appreciation for great service, you may do so by sharing your experience with others. All other providers within our spa accept and appreciate gratuity.

If you choose to tip according to percentage, it is standard to do so based on the full price of the service you have received. Credit card tips are accepted.

Average tip amounts are $10 and up.

Dr. Michelle Mendoza
Medical Progress

Date		Name