Shell
Laser MedSpa™
Dan H. Shell IV, M.D., FACS

Patient Information &
Massage Therapist Consent Form
General & Medical Information

Today's Date: _____

Name: _____
First MI Last

Birthdate: _____/_____/_____ Age: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Occupation: _____ Employer: _____

How did you learn about us, or who referred you? _____

List any medications, supplements, or any acne medications you are currently taking: _____

_____

Allergies to any Products or Medications? _____

Are you pregnant or suspect you could be pregnant or nursing? _____

I authorize Shell Plastic Surgery, Laser and MedSpa and its employees to speak with the following person(s) about my health care:

Name **Relationship**

_____

_____

_____

If I experience any pain or discomfort during the session, I will immediately inform the massage therapist so that the products and/or technique may be adjusted to my level of comfort. I further understand that facial should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Massage Therapist reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatments are contraindicated.

Patient Initials _____

Financial Policy

Shell Plastic Surgery's financial policy requires our office to collect payment for your office care at the time services are rendered. We accept cash, cashier's check, money order, personal check through TeleCheck, debit card, Mastercard, Visa, American Express and Discover. There will be a $40.00 fee charged to the patient on any returned check. We ask you to remember that the ultimate responsibility for full payment for our services rest with the adult patient or guarantor. If your account becomes delinquent and it becomes necessary for the account to be referred to an attorney or collection agency or suit, the patient or guarantor will be responsible for paying all patient charges, reasonable attorney fees, collection expenses and court costs.

The undersigned agrees that any and all services of every kind or nature provided by Shell Plastic Surgery, PLLC through any of its agents or employees (licensed or otherwise) shall be considered to constitute medical care and any action based upon the delivery of such services, or the failure to provide such services shall be governed by the provisions of document 11.-1-60, et seq. and document 15-1-36, The Mississippi Medical Malpractice Reform Act.

Patient Consent for Use of Credit cards, Debit Card, and Financing

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.
Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Shell Plastic Surgery, PLLC to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing company when they request such information to process an account and assist with payment.
I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy.
I agree that this noncredit card challenge agreement is irrevocable.

Patient Initials _____

Cancellation

As a courtesy to our patients, we have a waiting list for appointment availability. As a policy, we ask that you contact our office at least **48 hours** prior to your scheduled appointment if you need to cancel or reschedule so that we may offer the appointment to another patient. If you fail to cancel within 48 hours or do not show, there will be a fee incurred of $50 for a missed business opportunity which will be charged to your credit card that you submitted at the time your appointment was booked, we appreciate our patients and would like to thank you for your consideration of our policies.

I understand that I am financially responsible for all services rendered, regardless of the availability of any insurance coverage(s). I have read and understand this explanation of the financial policy of Dan H. Shell IV, M.D. and agree to accept responsibility as described.

Adult Patient/Guarantor: _____ Date: _____

HIPAA-Acknowledqement of Receipt of Notice of Privacy Practices:

I acknowledge the receipt of Shell Plastic Surgery's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling (662) 236-6465 or by requesting one at the following office:

Dan H. Shell, IV, M.D.
2680 West Oxford Loop
Oxford, MS 38655

Adult Patient/Guarantor: _____ Date: _____

Print Patient Name: _____

Photo Release (for American Board of Plastic Surqerv. Inc, ONLY):

I consent to the taking of photographs by Dr. Dan H. Shell IV or his designee of me of parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Dan H. Shell IV.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the healthcare services presently receive, or will receive, from Dr. Dan H. Shell, IV.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so, it won't have any effect on any actions taken prior to my revocation.

I understand that the information disclosed, or some portion l, hereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ('HIPAA).

I hereby grant permission for the use of any of my medical records including illustrations, photographs, or other imaging records created in my case, for use in examination. testing. credentialing. and/or certifying purposes by the American Board of Plastic Surgery, Inc.

I certify that I have read the above Authorization and Release and fully understand its term.

Adult Patient/Guarantor: _____ Date: _____

Massage and Health Information

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Date of Initial Visit: _____

1. Have you had a professional massage before? _____NO _____YES
   If so, how often do you receive massage therapy? _____

2. Do you have difficulty lying on your front, back or side? _____NO _____YES
   If yes, please explain _____

3. Do you have any allergies to oils, lotions or ointments? _____NO _____YES
   If yes, please explain _____

CLIENT INTAKE FORM – MASSAGE

Medical History

In order to plan a massage session that is safe and effective, I need general information about your medical history.

1. Are you currently under medical supervision? _____NO _____YES
   If yes, please explain _____
2. Are you currently taking any medication? _____NO _____YES
   If yes, please list _____
3. Please check any condition listed that applies to you:

( ) contagious skin condition	( ) phlebitis
( ) open sores or wounds	( ) deep vein thrombosis/blood clots
( ) easy bruising	( )joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
( ) recent accident or injury	( ) osteoporosis
( ) recent fracture	( ) epilepsy
( ) recent surgery	( ) headaches/migraines
( ) artificial joint	( ) cancer
( ) sprains/strains	( ) diabetes
( ) current fever	( ) decreased sensation
( ) swollen glands	( ) back/neck problems
( ) allergies/sensitivity	( ) fibromyalgia
( ) heart condition	( ) TMJ
( ) high or low blood pressure	( ) carpal tunnel syndrome
( ) varicose veins	( ) pregnancy; If yes, how many months? _____
( ) atherosclerosis	

   Please explain any condition that you have marked above _____
   _____
4. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____
   _____

Draping will be used during the session – only the area being worked on will be uncovered.

I, _____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client _____ Date _____
Signature of Massage Therapist _____ Date _____