



Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

The Tiffani Kim Institute may use and disclose information for treatment, payment, healthcare operations, or as required by law.

As a patient, you have the right to inspect, copy, and make corrections to your information, to request that your information be restricted and confidential. You also have the right to a report of the disclosures of your information; and a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received of this office's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Tiffani Kim Institute. I further understand that the office will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way

Patient or Representative Name (Please Print)

Patient or Representative Signature

Date

Patient refused to sign

Patient was unable to sign because:



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Laser Hair Removal Consent Form

The procedure planned is laser-assisted hair removal using the Candela Gentlemax.

The purpose of this procedure is to diminish or remove hairs. This procedure may require one or more treatments and may not produce permanent hair removal. Alternative methods are electrolysis, other laser-assisted hair removals, and various topical therapies (ie shaving, etc.)

I understand that the risks of this procedure include possible pain, infection, scarring, drug reactions or interactions or unforeseen complications. There is also a risk of mismatch in the color or the texture of the skin, temporary redness, hive-like reaction or bruising, brownish skin discoloration, activation of fever blisters (herpes), temporary increase susceptibility to sunburn or persistent pinkness for months.

I understand that there is a possibility that this procedure will fail, be unsuccessful, need to be repeated, or may require additional treatment of complications. If tattooed “permanent” make up or a “decorative” tattoo is in the area to be treated with laser hair removal, lightening of decorative tattoos, or blackening of makeup tattooing can occur.

I understand my responsibility for properly fulfilling the appropriate aftercare instructions as it is explained by a certified Aesthetician, board-certified physician assistant, or board-certified dermatologist at *Tiffany Kim Institute*.

Although part or all the cost of this procedure may, in rare situations, be reimbursed by insurance companies, many policies/companies consider this procedure cosmetic or not covered for various other reasons. I understand that I am responsible for all cost whether or not covered by my insurance.

I have been asked at this time whether I have any questions about this procedure, and I do not. I have complete understanding of both pre and post care instructions. I understand the procedure and accept the risks, and request that this procedure be performed by a provider at *Tiffany Kim Institute*.

Clients Signature: _____

Date: _____

Clients Name: _____
(Please Print)

Providers Signature: _____

Date: _____

Providers Name: _____
(Please Print)



LASER HAIR REMOVAL PRE & POST TREATMENT CARE

BE SURE TO NOTIFY YOUR LASER TECHNICIAN OF THE FOLLOWING:

- You are **pregnant, trying to get pregnant, or breast-feeding**
- You have used **Accutane** in the 6 months prior to your treatment
- You are on any **new medication**

THE DAY OF YOUR TREATMENT:

- Area to be treated **should be shaven within 24 hours** of treatment for optimal results.
- Do not apply lotion, makeup, moisturizers, perfume, powder, bath oil, deodorant on the area to be treated. These products can interfere with the treatments. Any such products may be removed immediately before treatments, but please let us know what was applied so that nothing is missed.
- Makeup can be applied immediately after the procedure, so bring what you need with you to your appointment.

PLEASE STOP AND BE MINDFUL OF THE FOLLOWING:

- Any type of Chemical Peel 2 – 4 weeks prior to and after the treatment on the area to be treated.
- Stop applying Retin-A, Renova, Tazorac, Differin, and Atralin 2 days prior and after, to the treatment area.
- Stop any type of depilatory treatments (**waxing, depilatory creams**) to the area of treatment, 4 weeks prior, and the duration of your series.
- **Avoid sun exposure** one month before and after treatment (**VERY IMPORTANT!**) If you cannot avoid skin exposure, be sure to use a sunscreen that has a SPF of at least 30 and has **zinc oxide** as an active ingredient. Apply sunscreen generously and reapply every 2 hours (more frequently if sweating or in water). **If you are tanned in the area to be treated, we cannot treat you to avoid burning the skin.**
- Stop **sun tanning** or using the **tanning bed** 2 – 4 weeks prior and after, to your treatment
- **Self Tanners/Spray Tans** should be avoided for at least two weeks prior to your treatment.
- **Aspirin** should be *avoided* for 10 days prior to and 2 days after treatments. If you were told to take aspirin daily by a doctor, then please ask us, or ask your prescribing doctor before stopping it.
- Plan to avoid **strenuous exercise** for 24 hours **after** to prevent reopening of the treated blood vessels.

WHAT TO EXPECT:

- It is normal to see slight redness and swelling around the hair follicle. The hairs may even appear damaged or singed. If severe adverse reactions occur, please contact TKI at 312-260-9020.
- Remember that we are only able to effectively treat the hairs that are in the **growth phase** of the hair cycle. Treated hairs will gradually be shed 1-2 weeks after your treatment. Those hairs that are in the resting phase of the hair cycle will simply fall out at their usual pace.
- The laser hair removal is not effective on vellus (peach fuzz) hair



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Laser Consultation Form

Name: _____ Age _____ Sex _____ Date _____

Area(s) to be treated today: _____

Skin Type (I-IV): Fair Olive Dark Asian/Hispanic Black

Hair Type: Coarse Fine Comments: _____

Hair Color: Black Brown Red Blonde Gray Other

Allergies: _____

Are you Pregnant? Yes No

Are you currently taking any medications?

(Please list if any, Accutane, Aspirin, Antibiotics, Antiviral, Coumadin, Photosensitivity drugs such as St. John's Wort)

List medications and dosages:

Please list any topical medications you are using:

Present Illnesses (including history of any autoimmune disease, HSV1, or HSV2):

Recent cosmetic procedures in area to be treated (chemical peels, exfoliation, injectables, tattoos):

History of keloids/hypertrophic scars: Yes No

Tanning history (including direct sun, self tanners, spray tans) Please list and include last date of use:



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Previous Laser Treatment: (specify date/number of treatments/frequency/tissue response/device used, if known):

Previous Hair Removal History, if applicable:

- Wax epilation
- Mechanical Epilation
- Electrolysis
- Previous Laser Treatment
- Bleaching
- Shaving

Frequency and last use of above modalities:

Other type of treatment: _____

FOR STAFF ONLY:

After reviewing the recommendations, please have client initial each item

Recommendations: Discussion with provider

- _____ 1. Discuss treatment options (*testing, color of hair responds best, number of treatments*)
- _____ 2. Discuss client expectations: understand need for multiple treatments, after care, possible side effects, etc.
- _____ 3. Review in detail full treatment schedule process (waiting period, when to expect re-growth, shaving ONLY 6 weeks prior to/after treatment)
- _____ 4. Discuss possible side effects (hyper/hypopigmentation, purpura, scarring) and length of time to expect healing if side effects occur.
- _____ 5. Discuss specifics of are to be treated, test small area for tissue response BEFORE full treatment (provider should protect eyes/brow, nose, ears when treating)
- _____ 6. Discuss avoidance of sun exposure and the use of sunscreen during entire program.
- _____ 7. Discuss sensation of laser and the option for topical anesthesia.
- _____ 8. Discuss benefits of laser treatment, possible long-term hair removal, and laser safety.
- _____ 9. Discuss cost (payment schedule, cost of multiple versus single payment per visit).

Comments:

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been answered to my satisfaction.

Signed: _____ Date: _____

Witness: _____ Date: _____

Our Cosmetic Dermatology services employ state-of-the-art technologies and the highest quality skin care products available. Our dermatologist has carefully chosen all our cosmetic treatment options and products. Most of our products are not sold in stores. These products are only available through a physician and do not require a prescription.

We are better able to address your needs if we know what concerns you most. Please put a check mark in front of one or more of the applicable boxes below. We are happy to give you more information and answer questions about any of our services.

I am most concerned with:

- | | |
|--|--|
| <input type="checkbox"/> Overall skin tone and texture
<input type="checkbox"/> Redness on my face
<input type="checkbox"/> Blood vessels on the surface of the skin
<input type="checkbox"/> Discolorations or brown spots
(please note location) _____
<input type="checkbox"/> Fine lines around the eyes
<input type="checkbox"/> Wrinkles between my eyebrows
<input type="checkbox"/> Wrinkles on my forehead
<input type="checkbox"/> Wrinkles around my mouth
<input type="checkbox"/> Creases between my nose and my mouth
<input type="checkbox"/> Creases between my mouth and my chin or jaw line
<input type="checkbox"/> The fullness of my lips
<input checked="" type="checkbox"/> Unwanted hair | <input type="checkbox"/> The appearance of the backs of my hands
<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Spider veins
<input type="checkbox"/> Heavy underarm and/or palm sweating
<input type="checkbox"/> Skin tags/unwanted moles/"bumps" or unwanted growths
<input type="checkbox"/> Acne/skin breakouts
<input type="checkbox"/> Scarring
<input type="checkbox"/> Other (please describe below) _____

_____ |
|--|--|

Please put a check mark whether you would be interested or not interested in the following options:

- | | | | | |
|---|--|---|---|--|
| A topical treatment routine that may include products such as a cleanser, sunscreen or anti-aging lotion/cream. | A non-invasive treatment plan such as superficial chemical peels or laser procedures which would require multiple treatment sessions at some regular interval. | A treatment that would involve injections such as BOTOX™, collagen/Restylane™ (or other filler) or Sclerotherapy. | A series of acupuncture treatments for facial rejuvenation, anti-aging and longevity, stress management and/or weight loss (circle all that apply). | One or more sessions with a licensed dietitian to address individualized nutrition, computerized nutrition analysis, healthy recipe revision, a supermarket tour and/or cooking classes (circle all that apply). |
| <input type="checkbox"/> Interested
<input type="checkbox"/> Not interested | <input type="checkbox"/> Interested
<input type="checkbox"/> Not interested | <input type="checkbox"/> Interested
<input type="checkbox"/> Not interested | <input type="checkbox"/> Interested
<input type="checkbox"/> Not interested | <input type="checkbox"/> Interested
<input type="checkbox"/> Not interested |

Please answer the following questions:

Have you had any cosmetic treatments in the past? Please indicate which ones and whether your response was favorable:

What skin care products are you using now? _____

Are you planning a vacation in the sun in the next six months? If so, when: _____



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Patient Consent and Authorization

My signature acknowledges that I have provided complete, accurate information and authorizes the physician to examine and treat me.

- I have received this physician's Notice of Privacy Practices.
- Federal privacy rules permit my personal and medical information to be used and disclosed without my permission for billing, medical treatment and healthcare operations. For other purposes, my information will only be released with my written permission.
- I authorize release of any medical information necessary to process insurance claims, and I authorize payment of medical benefits directly to the physician.
- I understand that all labwork is sent to an outside laboratory and I may be billed separately by the lab and I am able to receive copies of those reports from this office.
- I understand that my insurance company may not cover services due to:
 - Lack of Coverage
 - Non-Covered Services
 - Services not meeting their definition of "medical necessity"
 - Too many services within your insurance carrier's definition of "time period"

I **DO** **DO NOT** request a chaperone in the exam room during the physical portion of my examination.

I have no objection to the doctor and/or his staff discussing my medical treatment with:

Dr. _____ (Primary Care Physician)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I DO NOT OBJECT TO:

- Phone calls to my ___ home ___ place of employment ___ cell phone.
- ___ Messages left on my answering machine/voice mail.
- ___ Messages left with one of the people listed above.

Please note: All mail will be sent to your home address and no information will be FAXed or emailed to you without your written consent.

Printed Name: _____

Signature: _____ **Date:** _____

This practice reserves the right to change its privacy practices as described in the Notice. Revised Notices will be made available upon request.



Tiffani Kim Institute Medical History

Patient: _____ Male Female Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, please list allergies below:

1. _____ 2. _____

Are you allergic to nickel? YES NO

List all Medications you are currently taking:

1. _____ 2. _____
3. _____ 4. _____

Past Medical History/Have you had any of the following (please check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Heart Disease/Murmur/Angina | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other _____ | |

Do you drink alcohol? YES NO If YES _____ drinks per day

Do you use IV drugs? YES NO If YES, what? _____ How much and how often? _____

Have you had or have you been exposed to HIV (AIDS)? YES NO

Have you ever had dental anesthesia (Novacaine)? YES NO Any bad reaction? YES NO

Skin:

When you are exposed to sun do you: Tan only Tan and burn Burn

Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO If YES, who? _____

Do you have a history of any specific skin diseases? YES NO

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

Do you smoke? YES NO If YES, how much? _____ per day

Do you bleed easily? YES NO

Are you pregnant? YES NO N/A Due Date: _____

Do you have artificial joint(s)? YES NO

What is your occupation? _____

What are your hobbies? _____

Completed by: Patient
 Medical Assistant _____
Initials _____ Reviewed by _____



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Treatment Agreement

- _____ I understand that Candela Laser hair treatments are for **permanent** reduction of the hair in treated areas. Successful treatments will be evidenced by 50 – 90% reduction at the end of the 6th treatment.
- _____ It has been explained to me that many factors influence hair growth including, but not limited to: medical conditions, hormones, genetics, age, and that approximately 10% of the population are non-responders to hair reduction treatments. These factors make it impossible for the Tiffany Kim Institute to place a guarantee on the results of my treatment.
- _____ I understand that hair reduction treatment is most successful when a hair and its follicle are targeted during the active growth phase. For this reason, I will come for treatments at the intervals recommended to me by the Tiffany Kim Institute to maximize the effectiveness of my hair reduction.
- _____ I will **not** have any sun exposure for 4 weeks prior to my treatment. I will also **not** use any type of artificial tanning including tanning beds, sprays, and creams. I understand that failing to disclose tanning or artificial tanning may cause significant burning to my skin.
- _____ It has been explained that any type of lightening or removal of hair from it's follicle can make my treatments ineffective. Shaving or clipping hair is ok.
- _____ Understanding all of the above, I know that fees paid for hair treatments are NON-REFUNDABLE.
- _____ Upon observing any adverse effects to my skin/hair following a treatment I agree to call the Tiffany Kim Institute immediately at 312-260-9020.

Patient name (printed)

Witness name (printed)

Signature

Date

Signature

Date



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Pre-Treatment Checklist – Laser/ IPL Treatment

Patient Name: _____ DOB: _____

Allergies: _____

Current Medications: _____

FP Skin Type: I II III IV V VI

Exclusion Criteria:		Yes	No
1	Pregnant or possibility of pregnancy, postpartum or nursing		
2	Abnormal photosensitivity (sensitive reaction to sun)		
3	Recent sun-exposure, use of tanning beds or self-tanners		
4	Inflammatory skin conditions (dermatitis, etc)		
5	Hx of cold sores, open lacerations or abrasions on the treatment area		
6	Use of oral isotretinoin (Accutane®) within the past year		
7	Use of medications or over-the-counter supplements that may cause photosensitivity (antibiotics, St John's Wart, etc)		
8	History of vitiligo or psoriasis (koebernizing skin disorder)		
9	Any recent resurfacing procedures: fraxel, chemical peels, dermabrasion, etc.		
10	History of keloids or hypertrophic scarring		
11	Presence of tattoo, permanent makeup, or moles in the treatment area		
13	Active Systemic Lupus or any active autoimmune disorder		
14	Uncontrolled Diabetes		
15	Active Cancer (currently on chemotherapy or radiation)		
16	Active HIV/ AIDS/ Hepatitis		
17	Blood-thinning medication (aspirin, coumadin, ibuprofen, etc) in the last 7 days		
18	Use of Retin-A or glycolic acid in the last three days		



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SKIN TYPE EVALUATION

Name Date

POINTS

	0	1	2	3	4	SCORE
What color are your eyes?	Light blue, grey, green	Blue, grey, green	Blue	Dark brown	Brownish black	
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut, Dark blonde	Dark brown	Black	
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown	
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None	
Total for Genetic Disposition =						

	0	1	2	3	4	SCORE
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never burns	
To what degree do you turn brown?	Rarely or never	Light color tan	Reasonable tan	Tans very easily	Always turns dark brown	
Do you turn dark brown within several hours of sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face respond to sun exposure?	Very sensitive	Sensitive	Normal	Very resistant	Never had any problem	
Total for Reponse to Sun Exposure =						

	0	1	2	3	4	SCORE
When did you last expose your face/body to sun (include artificial exposure)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Did you expose the area to be treated to sun?	Never	Seldom	Sometimes	Often	Always	
Total for Tanning Habits =						

Total for Genetic Disposition = _____

Total for Reponse to Sun Exposure = _____

Total for Tanning Habits = _____

TOTAL SKIN TYPE SCORE = _____

TOTAL SCORE	FITZPATRICK SKIN TYPE
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V