FOCUS
AESTHETICS

PATIENT INFORMATION

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Sex: [ ] Male [ ] Female Ethnicity: _____ Race: _____ Marital Status: _____

Email Address: _____

Cell Number: _____ and/or Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

Preferred Pharmacy: _____ Address: _____

How did you hear about us? _____ Whom may we thank? _____

Do you have an Aspire Rewards account? [ ] Yes [ ] No Cell Number or Email on account: _____

Do you have an Allē Rewards account? [ ] Yes [ ] No Cell Number or Email on account: _____

PLEASE FILL OUT IF PATIENT IS A MINOR

LEGAL GUARDIAN, PARENT, SPOUSE OR POWER OF ATTORNEY INFORMATION

Name: _____ Relationship to Patient: _____

Cell Number: _____ and/or Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

OUR FINANCIAL POLICY

Focus Aesthetics' services and products are not covered by insurance. We accept the following forms of payment: cash, personal check, Visa, MasterCard, Discover, or American Express. Use of a combination is acceptable. We also accept financing through CareCredit payments. To see if you are eligible, you may use their official website at www.carecredit.com to sign up. Payment is due on the day services are performed or the product is purchased. All sales are final on all of the products, we have a no refund or exchange policy on the products. Discounts/Specials given on specified services that are pre-paid cannot be exchanged for other services. A refund request for a portion of an unused prepayment package will need to be reviewed by our Financial Department for approval.

_____

Patient Initials

HEALTH QUESTIONNAIRE

Please explain why you are here today: _____

_____

Do you have any current medical illnesses or active infections we should know about? _____

_____

Please list all allergies and/or skin sensitivities: _____

_____

Please list all medications you are currently taking: _____

_____

Have you been on Accutane? [ ] Yes [ ] No If so, please specify the start/end dates: _____

Please list all major illnesses, hospitalizations, and surgeries with their approximate dates: _____

_____

_____

_____

_____

Do you smoke? [ ] Yes – How often? _____ [ ] No – When did you stop? _____

Do you drink alcohol? [ ] Yes – How often? _____ [ ] No – When did you stop? _____

Have you gotten any vaccinations or dental work in the last two weeks or the next two weeks? [ ] Yes [ ] No

If yes, please specify: _____

Are you currently pregnant or breastfeeding? [ ] Yes [ ] No

What are your skin concerns? _____

_____

Do you have a history of keloid scarring, hypopigmentation, or hyperpigmentation? [ ] Yes [ ] No

If yes, please specify: _____

Have you ever gotten a chemical peel, laser, or any type of facial procedure? [ ] Yes [ ] No

If yes, please specify: _____

What is your daily sun exposure? _____

Please list all skincare products you are currently using: _____

_____

_____

_____

_____

THIS ARBITRATION AGREEMENT is made between North Florida Surgeons, P.A., for and on behalf of itself and its subsidiaries, affiliated professional associations, physicians (including physicians providing medical services through a subsidiary of North Florida Surgeons, P.A.), agents, employees, servants, or any of the foregoing, referred to hereinafter as "Doctor" and the above referenced patient ("Patient"). It is the intention of the parties to this Arbitration Agreement to bind not only themselves, but also their heirs, personal representatives, guardians and any persons deriving claims through or on behalf of the patient.

It is understood by the Patient that he or she is not required to use North Florida Surgeons, P.A. or any Doctor and that there are numerous other physicians located near the Patient who are qualified to provide care to Patient.

In the event of any controversy or dispute, which might arise between Doctor and the Patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnosis, treatment, or care of the Patient, or payment of surgical fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Federal Arbitration Act, 9 U.S.C. §§ 1-16.

Other than what may be conflict with this Arbitration Agreement, the laws of the State of Florida shall apply to any dispute between Doctor and the Patient. The Florida Rules of Civil Procedure shall apply for discovery purposes only.

Prior to commencing any action under this Arbitration Agreement, Patient must comply with the presuit notice and investigation requirements of Chapter 766, Florida Statutes. Any arbitration under this Arbitration Agreement must be commenced by filing of an application for arbitration within the applicable statue of limitations for the controversy or dispute at issue.

This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All arbitrators shall be selected from the following Florida counties: Alachua, Clay, Duval, Nassau, St. Johns and Volusia. The panel of arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be enforced by a court of law if necessary. Arbitration shall be conducted in Duval County, Florida.

In the event that either party to this Arbitration Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, including the appointment of the arbitrator and hearings to resolve the dispute, despite the refusal to participate or the absence of the opposing party. The arbitrators shall render a binding decision without the participation of the party opposing arbitration or despite his or her absence at the arbitration hearing.

Except for legal reporting requirements, all arbitration proceedings and outcomes under this Arbitration Agreement will be confidential and private. The parties shall be required to attend non-binding mediation in Duval County, Florida prior to arbitration.

The Patient understands that the Patient has a constitutional right under Article 1, Section 21 of the Florida Constitution of Access to courts as follows: "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." The Patient understands and acknowledges that signing this Arbitration Agreement waives this constitutional right.

Should any sentence(s) of this Arbitration Agreement be declared unenforceable or in conflict with the law, the sentence(s) shall be severed and the validity of the remaining parts and provisions shall not be affected by such holding.

The Patient has had an opportunity to read this Arbitration Agreement, or to have it read to him or her if necessary. The Patient understands English or has had this Arbitration Agreement translated for him or her by _____. The Patient has had an opportunity to ask questions about this Arbitration Agreement. The Patient understands this Arbitration Agreement and has no unanswered questions.

The Patient has not been coerced or compelled to sign this Arbitration Agreement, and does so of his or her own free will. The Patient may consult with an attorney before signing this Arbitration Agreement.

BY SIGNING THIS ARBITRATION AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO ALL OF THE ABOVE TERMS AND CONDITIONS.

Patient Signature: _____ Date: _____

Parent, Guardian or Legal Representative Signature: _____

Relationship to Patient: _____

Witness Signature: _____

Physician Signature: _____