



COVID-19 Liability Waiver

Due to the 2019-2020 outbreak of the novel Coronavirus (COVID-19), NuVo Aesthetic & Wellness is taking extra precautions with the care of every client to include health history review and enhanced sanitation/disinfection procedures in accordance with the CDC.

Symptoms of COVID-19 include:

- Fever
- Fatigue
- Dry Coughing
- Difficulty breathing

I agree to the following:

(Please check the following)

___ I understand the above symptoms and affirm that I, as well as all household members, do not currently have, nor have experienced the symptoms listed above **WITHIN THE LAST 14 DAYS.**

___ I affirm that I, as well as all household members, have not been diagnosed with COVID-19 **WITHIN THE PAST 30 DAYS.**

___ I affirm that I, as well as all household members, have not knowingly been exposed to anyone diagnosed with COVID-19 **WITHIN THE PAST 30 DAYS.**

___ I affirm that I, as well as all household members, have not traveled outside of the country, or to any city considered to be a "hot spot" for COVID-19 infections **WITHIN THE PAST 30 DAYS.**

___ I understand that NuVo Aesthetic & Wellness cannot be held liable for any exposure to the COVID-19 virus caused by misinformation on this form or the health history provided by each client.

NuVo Aesthetic & Wellness is following these enhanced procedures to prevent the spread of COVID-19:

- Prepayment for services available if clients prefer contactless checkout
- Additional time included between appointments to prevent client contact with each other
- Guests accompanying those scheduled for services discouraged
- Each client required to wash hands upon arrival and before leaving
- Your Nurse/Doctor/Esthetician will thoroughly clean hands and wear nitrile gloves during all treatments
- Your Nurse/Doctor/Esthetician will wear a clean set of gloves and cloth mask for each client
- All skincare product bottles used during treatment will be placed on the trolley for disinfection and disposable items will be used when possible
- All surfaces will be wiped thoroughly with hospital grade disinfectant before and after each client according to the manufacturer's directions

By signing below, I agree to each statement above and release NuVo Aesthetic & Wellness from any and all liability for the unintentional exposure or harm due to COVID-19.

NuVo Aesthetic & Wellness agrees to abide by these standards and affirms the same.

Printed Name: _____

Signature: _____

Date: _____



CLIENT INFORMATION AND MEDICAL HISTORY

All information is strictly confidential.

PERSONAL HISTORY

First Name _____

Home Phone _____

Last Name _____

Work Phone _____

Mobile Phone _____

Address _____

Zip Code _____

Gender _____

City _____

Ethnicity _____

State _____

Occupation _____

E-mail _____

Birthdate _____

Age _____

Emergency contact name and phone number _____

How did you hear about us? _____

Which of the following best describes your skin types? (Please circle **one** skin type number)

1. Always burns, never tans
2. Always burns, sometimes tans
3. Sometimes burns, always tans
4. Rarely burns, always tans
5. Brown, moderately pigmented skin
6. Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? YES NO

Are you currently under the care of a dermatologist YES NO

Please list *all* medications _____

Do you have any allergies to medications? _____

Are you currently taking antibiotics? _____

Do you take any medications for hearts conditions? _____

Are you on any mood altering or anti-depression medication? _____

What topical medications or creams are you currently using? _____

What herbal or other supplements do you use regularly? _____

<i>Medical History (past or present)</i>	YES	NO	<i>Medical History (past or present)</i>	YES	NO
Active skin infection or irritation			Autoimmune disease		
Darkening of the skin (hyperpigmentation)			Bleeding/clotting disorder		
Lightening of the skin (hypopigmentation)			Cancer		
Thick or raised scarring			Cold sores		
Used Accutane in the past 6 months			Eczema/psoriasis		
Using Retinol or Glycolic acid			Herpes		
Currently smoke or use other tobacco			Hepatitis		
Regular alcohol consumption			Pace maker/ defibrillator		
Birth control/hormone replacement			Polycystic ovarian syndrome		
Tattoos/permanent make-up			Thyroid disorder		
If "Yes" please explain:			If "yes" please explain:		

Do you have any other health problems or medical conditions not listed?

FOR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? YES NO
 Are you breastfeeding? YES NO
 Are you using contraception? YES NO

I certify that the preceding Personal, Medical, and Medication history statements are true and correct. I am aware that it is my responsibility to inform the doctor, esthetician, or other health professional of my current medical or health conditions and to update this history in timely fashion. A current and accurate medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____



FINANCIAL POLICY

Please take a moment to read this document thoroughly, sign and date the bottom indicating that you understand and agree to comply with these policies.

- **Payment is due at the time services are provided.** We accept cash, credits, and checks.
- **Payment Plan:** NuVo Aesthetic & Wellness offers 90-day no finance on services rendered for treatments over \$100 per session. NuVo will hold your card on file until the balance is paid in full. At the end of the three-month term of each service, the office reserves the right to charge 18% interest on any remaining balance. Any unpaid balance over 60 days on your account may be assessed a late fee. After 120 days, your account may be assigned to a collection agency. You will be responsible for 100% of our fees as well as any additional fees incurred to resolve this matter. (Payment plan not valid for groupons, laser lipo, acupuncture, massages, and waxing packages.)
- **Returned Checks.** A \$40.00 processing fee will be assessed for any check returned by the bank for reason. This may result in refusal of payment in the future.
- **Broken appointments.** In the event that you unable to make your scheduled appointments, please cancel at least 24 hours prior to the appointment. Canceled or changed appointments with less than 24 hours' notice will result in a fee of \$25 per appointment. For Package plan purchases, one session may be forfeited in lieu of a fee for missed appointments.

If you are more than 15 minutes late for your appointment you will be asked to reschedule.

Terms subject to change without notification.

I have read, understand, and agree to all the terms of NuVo Aesthetic & Wellness financial policy.

Client Printed Name

Client Signature

Date



HIPAA NOTICE OF PRIVACY PRACTICES

(Effective December 19, 2018)

At NuVo Aesthetic & Wellness, Dr. Sunil Patel and his medical staff understand that health information about you is very personal and we are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to protecting your health information. We create a record of the care and services you receive from us, and this record helps to provide you with quality care and to comply with certain legal requirements. This Notice applies to all the records of our care generated by us and informs you about the ways in which we may use and disclose information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For Treatment
- For Payment
- For Healthcare operations
- As required by law
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates
- For any services provided by NuVo Aesthetic & Wellness
- For appointment reminders

Your rights regarding Health Information about you:

- Right to inspect and copy
- Right to amend
- Right to Accounting and Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communication

Your Medical Records: The original copy of your and/or electronic medical record is the property of NuVo Aesthetic & Wellness and Dr. Sunil Patel. You may request a copy of your records to be transferred by completing a medical records release form.

Changes to this Notice: We reserve the right to change this notice. We will post a copy of current notice in our facility with the current effective date.

Complaints: if you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the Office Manager at NuVo to file a complaint. For complete, detailed information regarding privacy law, visit www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html.

Permission to Share your Health Information: We are required to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss your treatment records or other personal information with your significant other, family members, or any other individuals, please fill in their name and relationship to you in the section listed below.

Acknowledgment of Receipt of NuVo Aesthetic & Wellness HIPAA NOTICE OF PRIVACY PRACTICES:

We request that you sign this form acknowledging you have received, read, and reviewed NuVo Aesthetic & Wellness HIPAA Notice of Privacy Practices. If the patient is a minor, the legal guardian is automatically appointed by law to provide/receive protected information on behalf of the patient. I will notify Dr. Patel and/or his staff of any changes or updates to this record. This acknowledgment will become part of your records.

Patient Name: _____ Date: _____

Patient Signature: _____

Relationship to Patient: _____



Intravenous (IV) Infusion Therapy Intake Form

Patient Information:

Name: _____ Date: _____

DOB: _____ Age: _____ Sex: M/ F

Emergency Contact Name: _____ Phone: _____

What are your main complaints? (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Fatigue or low energy | <input type="checkbox"/> Asthma and Allergies |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Recent surgical procedure |
| <input type="checkbox"/> Poor diet due to busy lifestyle | <input type="checkbox"/> Recent illness |
| <input type="checkbox"/> Brain fog or trouble concentrating | <input type="checkbox"/> Cold or flu symptoms |
| <input type="checkbox"/> Low mood or depression | <input type="checkbox"/> Facial wrinkles or fine lines |
| <input type="checkbox"/> Headaches or migraines | <input type="checkbox"/> Dull or dry skin |
| <input type="checkbox"/> Weight gain or difficulty losing weight | <input type="checkbox"/> Malabsorption issues |
| <input type="checkbox"/> Slow metabolism | <input type="checkbox"/> Other _____ |

What are you hoping to benefit from by getting IV Therapy?

Medical History

Are you pregnant or breastfeeding? YES / NO

Have you ever been told that you have an electrolyte imbalance or other abnormal labs? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Hypermagnesemia (High magnesium levels) | <input type="checkbox"/> Hemochromatosis (High iron levels) |
| <input type="checkbox"/> Hypercalcemia (High calcium levels) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hypokalemia (Low potassium levels) | |

Are you a diabetic? YES / NO If yes, Type 1 or Type 2? _____

Are you a smoker? YES/ NO If yes, how much do you smoke? _____

How many alcoholic drinks do you consume in a week? _____

Do you use recreational drugs? YES/ NO If yes, which ones and how often? _____

Please list everything you are currently taking:

Prescription Medications – Strength – Frequency – Condition being treated

Over the Counter Drugs – Strength – Frequency – Condition being treated

Vitamins and Other Supplements – Strength – Frequency – Condition being treated

Do you take Digoxin (Lanoxin) for a heart problem? YES/ NO

Do you take any diuretics or water pills? YES/ NO If yes, please list: _____

Do you take steroids, i.e. Prednisone? YES/ NO If yes, please list: _____

Do you have any medication or food allergies? YES/ NO If yes, please list: _____

Do you have any of the following conditions? (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Blood pressure problems (High or Low) | <input type="checkbox"/> Optic Nerve Atrophy or Leber’s Disease |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Stroke or “mini-stroke” | <input type="checkbox"/> G6PD Deficiency |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Parathyroid problems (High levels) |
| <input type="checkbox"/> Asthma | |

List any other medical conditions you have (not mentioned above):

List of all surgical procedures you’ve had with approximate dates:

Is there anything else you’d like the nurse and physician to know?



IV Therapy Consent Form

This document is intended to serve as informed consent for your Intravenous (IV) Infusion Therapy as ordered by the physician at NuVo Aesthetic & Wellness.

Please initial by the following statements.

___ I have informed the nurse and/or physician of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the nurse and/or physician of my medical history.

___ Intravenous Infusion Therapy and any claims made about these infusions have not been evaluated by the US Food and Drug Administration (FDA) and are not intended to diagnose, treat, cure, or prevent any medical disease. These IV infusions are not a substitute for your physician's medical care.

___ I understand that I have the right to be informed of the procedure, any feasible alternative options, and the risks and benefits. Except in emergencies, procedures are not performed until I have had the opportunity to receive such information and to give my informed consent.

___ I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include but not limited to:
 - a. Occasionally: Discomfort, bruising and pain at the site of injection.
 - b. Rarely: Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
 - c. Extremely Rare: Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death
4. Benefits of intravenous therapy include:
 - a. Injectables are not affected by stomach, or intestinal absorption problems.
 - b. Total amount of infusion is available to the tissues.
 - c. Nutrients are forced into cells by means of a high concentration gradient.
 - d. Higher doses of nutrients can be given than possible by mouth with intestinal irritation.

___ I am aware that other unforeseeable complications could occur. I do not expect the nurse(s) and/or physician(s) to anticipate and or explain all risks and possible complications. I rely on the nurse(s) and/or physician(s) to exercise judgement during treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all my questions answered.

___ I understand that I have the right to consent to or refuse any proposed treatment at any time prior to its performance. My signature on this form affirms that I have given my consent to IV Infusion Therapy, including any other procedures which, in the opinion of my physician(s) or others associated with this practice, may be indicated.

My signature below confirms that:

1. I understand the information provided on this form and agree to all statements made above.
2. Intravenous (IV) Infusion Therapy has been adequately explained to me by my nurse and/or physician.
3. I have received all the information and explanation I desire concerning the procedure.
4. I authorize and consent to the performance of Intravenous (IV) Infusion Therapy.
5. I release Dr. Sunil Patel, NuVo Aesthetic & Wellness, and all the medical staff from all liabilities for any complications or damages associated with my Intravenous (IV) Infusion Therapy.

Patient Name: _____ Date: _____

Patient Signature: _____

RN or Physician Name: _____ Date: _____

RN or Physician Signature: _____



Post-Care Instructions for Intravenous (IV) Infusion Therapy

How to care for yourself after your IV Vitamin Therapy infusion:

- Apply pressure to site for 2 minutes after IV has been removed
- Keep Band-Aid in place for 1 hour
- Warm packs and elevating your arm can be used for any bruising at the site
- Cold packs can be used for pain relief and to decrease any swelling at the site
- Any swelling should be significantly reduced in 24 hours
- Post IV infusion symptoms are uncommon. Dehydration is the cause of most symptoms and concerns.
- We encourage you to drink at least 1-2 16oz. bottles of water after your IV infusion.
- If not enough water is consumed, you may experience any of the following symptom: headaches, nausea, joint pain, blurred vision, cramping (GI and/or muscular), mental confusion or disorientation.

Most patients experience significant overall improvements:

- Better energy
- Better mental clarity
- Improved sleep
- Improvement of their complaints
- Overall feelings of well being

Patients commonly report one or two patterns after an IV Vitamin Therapy infusion:

- Patients generally feel better right away. Due to a busy lifestyle, many people are chronically dehydrated and deficient in vitamins and minerals causing them to not feel well. Once the patient is hydrated and the nutrients are replaced, their symptoms improve quickly.
- Patients sometimes feel tired or unwell. These patients are generally in the process of detoxifying. When toxins are pulled out of tissues, they re-enter the blood stream. They remain poisons, but they are now on their way OUT instead of on their way IN. Even when patients do not feel well at this stage, the process is one of healing and cleansing. After this period, an overall improvement in one's sense of well-being is generally reported.

How often will I need IV Vitamin Therapy infusions?

The number and frequency of treatments will vary depending on certain factors

- Condition being treated
- Current health status of the patient
- Response of the patient to the treatments

A general estimate of the number of treatments needed is discussed during the first visit. As we go along, we will develop a more specific treatment plan. Most patients will require at least 5-10 treatments. Depending on the response, some patients will then go on to maintenance therapy with occasional treatments.

Call NuVo Aesthetic & Wellness or your Primary Care Physician for:

- Any symptoms you are not comfortable with
- If any of the following are progressively worsening after your IV infusion:
 - Significant swelling over the IV site
 - Redness over the vein that is increasing in size
 - Pain in the vein/arm that is not improving over an 8-12 hour period
 - Headache that does not resolve with increased hydration or over-the-counter pain relievers like aspirin, Acetaminophen or Ibuprofen

If you feel like you are having a life-threatening emergency, please call 911.