



PATIENT INFORMATION

Date: _____

Name: _____ Date of Birth _____

Address: _____ Apt.: _____ Phone () _____

City: _____ State: _____ ZipCode: _____ Mobile() _____

Marital Status: M S D W Sep Social Security No. _____ E-Mail _____

May we e-mail you special promotions and upcoming events? Yes No

Patient's Occupation: _____ Employer: _____

Business Address: _____ Business Phone () _____

Spouse or Nearest Relative: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone () _____

Referred by: _____ Friend/Patient/Physician

Magazine News Our Website Television Commercial Search Engine _____

Training Candidate or Model at Rejuvalife?

Would you be interested in being considered as a candidate model for Dr. Berger's educational trainings for physicians on Silhouette Lift or Advanced Lipo procedures? Prices may be 30% – 50% less than the actual cost of the procedure. Dr. Berger performs physician trainings several times throughout the year teaching other physicians ground-breaking non surgical treatments. There is no guarantee that you will be suitable as a candidate, and training candidates are taken on a first come, first served basis. Yes No

HIPPA

I, _____ have been informed that a copy of our offices *Notice of Privacy Practices* is posted in the waiting room. A copy of this Notice will be furnished to me upon my request.

Signature: _____ Date: _____

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding: Unique Identifiers for health plans, providers, individuals, employers; Healthcare Transaction & Code Sets for transmitting data electronically; Privacy regulations over disclosure and use of health information; Security regulations over protections of electronic health information.

AUTHORIZATIONS

I authorize (practice name) to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Rejuvalife's determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and *if applicable* to process the insurance claim for services rendered at Rejuvalife Vitality Institute.

It is our policy to not release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following:

I authorize the doctor's office to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them, in writing, whenever this information changes.

Home telephone: Yes No Voice mail/Answering machine: Yes No Cell phone Yes No

Work phone: Yes No May we fax medical records for referrals? Yes No

Signature: _____

Date: _____

Please bring your Government issued ID to the front desk once the paper work has been completed.

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. If the status of my health changes, I will notify the doctors at Rejuvalife Vitality Institute. I authorize Rejuvalife Vitality Institute to take a picture of me for identification purposes if necessary. I understand that I may not be seen as a patient without this picture on file. (We are required by law to maintain the privacy of your protected health information).

Signature: _____

Date: _____



So Dr. Berger may best answer your questions during your consultation, what are you interested in learning more about?

- | | |
|--|--|
| <input type="checkbox"/> Body Sculpting | <input type="checkbox"/> Chemical Peel |
| <input type="checkbox"/> Smartlipo/Body Jet | <input type="checkbox"/> Skincare/Acne scar treatment |
| <input type="checkbox"/> Fat Transfer | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Cellulite Reduction | <input type="checkbox"/> Removal of brown marks |
| <input type="checkbox"/> Mesotherapy | <input type="checkbox"/> Removal of dark circles around eyes |
| <input type="checkbox"/> LipoDissolve | <input type="checkbox"/> Preventative Health & Wellness |
| <input type="checkbox"/> Silhouette Lift | <input type="checkbox"/> Hormone Replacement Therapy |
| <input type="checkbox"/> Skin Tightening | <input type="checkbox"/> Human growth hormone |
| <input type="checkbox"/> IPL Photofacial / Skin Rejuvenation | <input type="checkbox"/> Medical Weight Loss |
| <input type="checkbox"/> Pixel Skin Resurfacing | <input type="checkbox"/> Optifast |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Wrinkle reduction | <input type="checkbox"/> Fitness Evaluation |
| <input type="checkbox"/> Restylane/Perlane/Juvederm | <input type="checkbox"/> Lipotropic Injections |
| <input type="checkbox"/> Sculptra | |
| <input type="checkbox"/> Botox / Dysport | |

How soon would you consider having a procedure?

How much do you know about these procedures?

- | | |
|--|--|
| <input type="checkbox"/> I've just started my research | <input type="checkbox"/> I am ready to start immediately |
| <input type="checkbox"/> I have been researching for at least one year | <input type="checkbox"/> 1 month |
| <input type="checkbox"/> I know someone who has had the procedure | <input type="checkbox"/> 2-3 months |
| <input type="checkbox"/> I am ready to start a procedure | <input type="checkbox"/> 3-6 months |
| | <input type="checkbox"/> 6-12 months |
| | <input type="checkbox"/> 12 months or more |

Are you interested in 3rd party financing information such as Care Credit or Chase Financial which both offer Interest FREE financing. Ask us about it. It's easy to apply and we're happy to help with the process.

Yes No

Please feel free to ask us any questions. We are leaders in the fields of anti aging and non surgical cosmetic medicine and are happy to accommodate you and answer all your questions.

We hope you have a great consultation with Dr. Berger and our staff at Rejuvalife Vitality Institute.