



## **Directions to the Office**

### **If you are traveling North on I-95:**

Exit Butler Boulevard as you come off the exit ramp, stay in the right lane and proceed straight toward the light, which is Belfort Road. You will see signs for Belfort Road. Go straight toward Belfort but stay in the middle lane (the right lane of the lanes going left) and bear left at the light on to Belfort which will take you under the Butler overpass. Once on Belfort, go straight you will see St. Luke's Hospital on your right. You will pass St. Luke's Hospital and continue straight to the next light, Gate Pkwy West, turn right. Once on Gate Pkwy West, go straight about half quarter mile. The medical complex (Gate Parkway West Professional Center) is on the left. Our office building is to the left next to Gulani Vision Institute.

### **If you are traveling South on I-95:**

Take the Butler Exit turn left off the ramp on to Butler and immediately get into the right lane and take the first exit, which is the Belfort Road. You will see signs for Belfort Road. Go straight toward Belfort but stay in the middle lane (the right lane of the lanes going left) and bear left at the light on to Belfort which will take you under the Butler overpass. Once on Belfort, go straight you will see St. Luke's Hospital on your right. You will pass St. Luke's Hospital and continue straight to the next light, Gate Pkwy West, turn right. Once on Gate Pkwy West, go straight about half quarter mile. The medical complex (Gate Parkway West Professional Center) is on the left. Our office building is to the left next to Gulani Vision Institute.

### **If you are traveling If you are traveling West on JTB (from the beach):**

Take Southside North, get in the left lane and turn left at Gate Pkwy West, go about a mile and a half, you will see the medical complex (Gate Parkway West Professional Center) on the right. Our office building is to the left next to Gulani Vision Institute.



## Patient Information for Laser Hair Removal

### Our Technology and Experience

Our office was among the first to introduce laser hair removal to Jacksonville. We have three devices capable of performing long-term permanent hair reduction. Each one has specific advantages for specific individuals. Therefore, we can pick and choose the right machine for each patient.

Hair removal works best when there is color in the hair. People with light hair may see only moderate improvement and may need a greater number of treatment sessions. Dark hair responds best and white hair does not respond at all.

### What does it feel like?

Discomfort varies from patient to patient and laser to laser but is generally mild and well tolerated. The sensation may be like a slight sting for a fraction of a second. The lasers utilize cooling tips that not only protect the skin but also minimize the discomfort.

### How long do the treatments take?

An upper lip and chin can be done in 5 to 10 minutes. Underarms or bikini lines usually take 15-20 minutes. Legs and backs take longer.

### How many treatments are necessary?

Hair goes through 3 stages of development. It will only respond to the treatment in one stage, which is called the anagen (growth) stage. At any given time, only 20-30% of human hair is in the anagen stage. For this reason, it is necessary to treat an area at least 4 or 5 times with the treatments spaced 6 or more weeks apart in order to see the best and longest lasting results. In many cases, it may require 8 or more treatments, depending on your level of satisfaction. The industry standard is a 50-80% reduction in hair after treatment. If you desire greater reduction, you may require more treatments.

### Results – What should you expect?

Your skin may get slightly red or even develop a small crust that will peel. The laser may leave small red marks on your skin. The marks clear up in a few days. The hair that has been destroyed will sometimes grow out and then fall out in 2-3 weeks. However, if the hair doesn't fall out, this does not mean that the treatment was unsuccessful.

### Is it permanent?

Everyone gets some re-growth with time regardless of the technology used. You will get a permanent decrease in the amount of hair. The FDA screens and approves medical lasers. The FDA had approved the use of the term "permanent reduction" for our lasers. Most patients elect to have yearly touchups to capture any new growth.

Hair that grows back tends to be much more fine and less concentrated. For some this may mean a great decrease in the frequency with which you must shave or pluck. For others it may mean permanent cosmetic improvement because hair re-growth is minimal, very fine or completely absent.

**IMPORTANT** – As with many other lasers, it is not necessary to come in for treatment with significant visible hair. This avoids embarrassment. In fact, lasers work best when there is very little hair above the surface of the skin. Patients should come in with just enough growth so the technician can identify the areas needing treatment. We recommend shaving the night before.

### Pre and Post Care

Please do not wax, pluck or use depilatories for 2 weeks prior to appointment. Please remove all makeup or deodorant. Please use sunscreen and avoid direct sun exposure prior to and during the course of your treatments. Please let the office know of any new medications that you are taking, especially any antibiotics.



## PATIENT REGISTRATION

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Welcome to Quinn, MD! We are privileged to have the opportunity to include you as one of our patients and will make every endeavor to ensure that your visits with us are enjoyable.

Please take a few moments to answer the following questions so we can be of better service to you now and in the future. Keep in mind, your comments about our services and staff are welcome at anytime during or after your visit.

### How did you hear about Quinn, MD?

Brochure       Folio       Times Union       TV  
 Internet       Yellow Pages      Other \_\_\_\_\_

What information did you receive about the treatment you are seeking before this visit?

How can we improve our communication with you? \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City, St., Zip \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Email Address \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: S M D W  
Spouse: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Nearest Relative: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Who should we contact in case of an emergency? \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number \_\_\_\_\_

### INSURANCE/FINANCIAL INFORMATION

Primary Insurance Company: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Is this Policy a: HMO PPO PPC POS  
Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Is this Policy a: HMO PPO PPC POS  
Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Credit Card you wish to use at this office: VISA MASTERCARD AMERICAN EXPRESS  
Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

### Person Responsible for this account:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Who REFERRED you to our office?

Name: \_\_\_\_\_ Address: \_\_\_\_\_



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## Patient Skin History and Analysis

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Sports/Hobbies: \_\_\_\_\_

Occupation: \_\_\_\_\_

### General Information:

Have you ever seen a doctor for your skin? \_\_\_\_\_ For what procedure? \_\_\_\_\_

Family Physician/Other Physician \_\_\_\_\_

History of Skin Cancer (date, type, location): \_\_\_\_\_

Are you under care or do you have the following?

- Diabetes     Heart Condition     Pacemaker     Seizures     Hepatitis     Hemophilia  
 Lupus     Porphyria     Photosensitivity     HIV+

Have you or are you using any medications:

- Accutane     Retin-A     Topical Antibiotics     Diuretics     Birth Control  
 Oral Antibiotics

Have you ever been had any prior cosmetic peels?     TCA     Glycolic     Jessner's  
 Other \_\_\_\_\_

List any allergies: \_\_\_\_\_

*(Aspirin, Citrus fruits, Milk products, Aspirin, Benzoyl Peroxide, Skin care products)*

Are you pregnant, lactating or going through menopause?    YES    NO

Did you develop hyper-pigmentation from these hormone changes?    YES    NO

Do you get cold sores or fever blisters on the lips or face?    YES    NO

How many ounces of water do you drink per day? \_\_\_\_\_

How much caffeine do you drink per day? \_\_\_\_\_

How do you rate your skin?

- |                 |                |               |             |                        |
|-----------------|----------------|---------------|-------------|------------------------|
| ___ Dry         | ___ Normal     | ___ Oily      | ___ Acne    | ___ Scarring           |
| ___ Blackheads  | ___ Pimples    | ___ Sensitive | ___ Rosacea | ___ Broken Capillaries |
| ___ Whiteheads  | ___ Fine lines | ___ Wrinkles  | ___ Sagging | ___ Crow's feet        |
| ___ Brown spots | ___ Tight      | ___ Flaky     | ___ Shiny   | ___ Dehydrated         |
| ___ White spots |                |               |             |                        |

Please check the products you are currently using and list the **BRAND NAMES**:

- |  |  |                                      |
|--|--|--------------------------------------|
| <input type="checkbox"/> Cleanser _____    | <input type="checkbox"/> Soap _____        | <input type="checkbox"/> Toner _____ |
| <input type="checkbox"/> Moisturizer _____ | <input type="checkbox"/> Night Cream _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye Cream _____   | <input type="checkbox"/> Toner _____       | <input type="checkbox"/> Mask _____  |
| <input type="checkbox"/> Scrub _____       | <input type="checkbox"/> Sunscreen _____   |                                      |

**Sun History - How does your skin respond to the sun during the first 15 minutes of exposure?**

- \_\_\_ I    Always burns, never tans (Caucasian)  
 \_\_\_ II    Usually burns, tans with difficulty (Caucasian)  
 \_\_\_ III    Sometimes burns, tans average (Caucasian, Hispanic, Asian)  
 \_\_\_ IV    Rarely burns, tans easily (Hispanic, Asian, African American)  
 \_\_\_ V    Very rarely burns, tans easily (Hispanic, Asian, African American)  
 \_\_\_ VI    Almost never burns, tans easily (African American)

What do you specifically want to improve or change about your skin?

What areas do you want to treat?    \_\_\_ Face    \_\_\_ Neck    \_\_\_ Chest    \_\_\_ Back    \_\_\_ Hands

Clinician Signature: \_\_\_\_\_



## Laser Hair Removal Fee Sheet

Treatments spaced at 6-week intervals. Treatment prices are based on area treated, not amount of time at each session.

Face & Neck		
Upper Lip	\$100	15 min
Chin	\$100	15 min
Lip and Chin	\$150	15 min
Full Face (includes front of neck)	\$200	15 min
Back of Neck	\$150	15 min

Trunk		
Chest and Abdomen	\$400	30 min
Full Chest	\$250	30 min
Between breasts	\$100	15 min
Full Abdomen	\$200	15 min
Navel Line	\$100	15 min
Full Back (includes back of neck)	\$400	60 min
Upper Back	\$250	30 min
Lower Back	\$200	30 min
Buttocks	\$200	30 min

Extremities		
Underarms	\$150	15 min
Full Arm	\$400	30 min
Upper Arm	\$250	30 min
Forearm	\$200	30 min
Hands (includes fingers)	\$100	15 min
Full Legs	\$500	75 min
Bikini Line	\$200	15 min
Thighs	\$300	45 min
Lower Legs	\$250	30 min
Feet (includes toes)	\$100	15 min

I have read and understand the above information and agree to the fees as indicated above.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date



## Patient Policies: Appointment, Records, Disputes and Informed Consent to Treatment

### APPOINTMENTS

All appointment cancellations require at least 24 hours notice unless an emergency (documented) arises. Failure to give a 24-hour cancellation notice, or simply not showing will result in a \$25 office visit assessment. Call 904-296-0900 to cancel. Email notification is not an accepted form of cancellation.

### QUINN, MD SIGNATURE SERVICES

Signature Services are the Fraxel Laser, Varicose Vein treatments, Vein Removal procedures, and Laser Hair Removal treatment greater than an hour. All Signature Service cancellations require at least 24 hours notice unless an emergency (documented) arises. Failure to give a 24-hour cancellation notice will result in a \$100 Signature Service assessment. Call 904-296-0900 to cancel. Email notification is not an accepted form of cancellation.

### MEDICAL RECORDS POLICIES

For a copy of your medical records, please allow us 10-business days notice. There will be a charge of \$1.00 per page for the first 25 pages and \$0.25 for every page after. You will need a signed medical records release form to proceed.

Payment is due the day of the service unless previous arrangements have been made. Our office often distributes coupons to patients. Only one coupon can be redeemed per visit and it cannot be combined with another pre-arranged discount. Our office is proud to offer financing through CareCredit. This is a no interest payment plan for 12 months. Please see representative for information.

### DISPUTES AND INFORMED CONSENT TO TREATMENT

In the event of any dispute between me and Quinn, MD and/or any other person associated with Quinn, MD, I agree to submit a written claim of such dispute to Quinn, MD within one (1) year of this date. I acknowledge and agree that failure to timely make such a claim shall constitute a waiver of any and all rights and remedies related thereto.

Any claim made in accordance with the paragraph above, including, without limitation, claims for Professional Liability, Personal Injury, Contract, Warranty or other breach of duty, or the coverage of this arbitration provision, shall be settled by arbitration pursuant to the Florida Arbitration Code. By agreeing to arbitrate, I am waiving my right to a jury trial. Any such arbitration shall be conducted in Jacksonville, Florida. The arbitration of such issues, including determination of the amount of any damages suffered, shall be to the exclusion of any resolution of such issues in a court of law. The decision of the arbitrators shall be final and binding upon me, my heirs, executors, administrators, successors and/or assigns.

In the event any action is initiated for any breach, fault, or default of any of the terms, conditions, or provisions of this Agreement, then the party in whose favor judgment shall be entered shall be entitled to have and recover from the other party all costs and expenses, including attorneys' fees.

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All terms and conditions embodied in the Informed Consent to Treatment are to be interpreted and construed according to the laws of the State of Florida; any litigation would be filed in a Florida State Court.

If any part of this Informed Consent to Treatment is deemed to be unenforceable for any reason whatsoever, the remaining portions shall remain in full force and effect. Nothing herein shall be construed to constitute a waiver of, or any other limitation upon, any of the legal and/or equitable rights of Quinn, MD, all of which are hereby expressly reserved.

I understand that consent to arbitration is not a prerequisite to treatment at this clinic, and is voluntarily given by me. I understand there are other clinics where my needs can be addressed, but have chosen Quinn, MD even with all these conditions I have agreed to, and promises I have made.

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Patient Signature

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Date



## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 14, 2003* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Dr. Linda Quinn. Information on contacting us can be found at the end of this Notice.

### TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement. Furthermore, we will provide you with a treatment estimate describing or recommending treatment alternatives.

**Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances. We reserve the right to discuss your payment options with the individual financially responsible for your treatment.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. In addition, this may require speaking with your primary care physician, obtaining information from hospitals and/or labs directly relating to your treatment. Your information may also be disclosed to laboratories for the purpose of ordering blood tests.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

### YOUR PRIVACY RIGHTS AS OUR PATIENT

**Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$1.00 for each page and the staff time including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.



**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

**QUESTIONS AND COMPLAINTS**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing or request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Dispensed Medications:** You have a right to medication counseling by a provider in this office regarding any prescribed or dispensed medications.

**HOW TO CONTACT US**

Practice Name: Dr. Quinn MD      Privacy Officer: Dr. Linda Quinn      Telephone: (904) 296-0900

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**Notice to Patient:**

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Privacy Practices.

**Print Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Office Use Only**

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.                       Due to an emergency situation it was not possible to obtain an acknowledgement.
- We were not able to communicate with the patient.       Other (please provide specific details) \_\_\_\_\_

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_