Ekzotika Corp. d/b/a

Med Spa

Cosmetic Laser Professionals

TeleHealth Medical Intake Form

Today's Date_____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email Address_____ `Occupation_____

Date of Birth: _____ Sex: Female ____ Male ____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone:

---

1. Is this your first visit with us? ☐ Yes ☐ No
   If yes, how did you hear about us?_____
2. Would you like to subscribe to our email updates and specials? ☐ Yes ☐ No
3. Do you participate in online review sites such as Yelp? ☐ Yes ☐ No
4. What is the best way to communicate with you between visits?

   ☐ Email ☐ Home Phone

   ☐ Work Phone ☐ Cell Phone

Ekzotika Corp DBA Cosmetic Laser Professionals Med Spa
8501 SW 124th Ave. Suite 212A Miami, FL 33184 www.CosmeticLaserProfessionals.com

5. Is there any place you do NOT want us to leave a message?

Please describe_____

6. Are you pregnant or nursing? Yes ☐ No ☐

7. Do you have any allergies? Yes ☐ No ☐

If yes, please describe_____

8. Do you smoke? Yes ☐ No ☐

9. Do you Drink Alcohol? Yes ☐ No ☐ If yes: Socially ☐ Occasionally ☐ Drinks per week_____

10. Do you have any history of substance abuse? Yes No

11. Do you have high Blood pressure? Yes ☐ No ☐ Are you on any High Blood pressure medications? Yes ☐ No ☐

If you are on high Blood pressure medications, please list:

12. Are you currently on any prescription medication? Yes ☐ No ☐

If yes, please describe_____

13. Are you on any over-the-counter medications? Yes ☐ No ☐

If yes, please describe_____

14. Are you on any mood altering or anti-depression medication? Yes ☐ No ☐

If yes, please describe_____

15. What are your vital signs? Blood Pressure:_____ Pulse:_____

16. Do you have any medical conditions? If yes, please describe

_____

_____

_____

_____

Ekzotika Corp DBA Cosmetic Laser Professionals Med Spa
8501 SW 124th Ave. Suite 212A Miami, FL 33184 www.CosmeticLaserProfessionals.com

17. Which of these make your weight loss harder? Please mark all that apply.

- ☐ Lack of time
- ☐ Lack of energy
- ☐ Work schedule
- ☐ Responsibilities caring for loved ones
- ☐ Emotional eating
- ☐ Stress
- ☐ Physical health concerns
- ☐ Other:

18. Has your weight changed over the past year? No☐ Yes☐ I gained _____ pounds, **or** Yes, I lost pounds

19. Are you currently following a diet? No☐ Yes: ☐ If so, what diet:_____

20. Do you exercise? No☐ Yes☐

21. How many days do you exercise per week? _____

22. How long has it been since you were at your ideal weight? _____

How much do you currently weigh?

23. Do you have a primary care provider? No☐ Yes☐

If yes, please list provider's name and phone: _____

24. Medicine List (add additional sheet if needed)

Medicine including over the counter, supplements and herbals	Dose / Strength	How often (frequency)	Why do you take it?

Ekzotika Corp DBA Cosmetic Laser Professionals Med Spa
8501 SW 124th Ave. Suite 212A Miami, FL 33184 www.CosmeticLaserProfessionals.com

CANCELLATION/APPOINTMENT POLICY & SPA CHECK- IN

A **24-hour notice** is REQUIRED for any rescheduling or cancellation of your appointments. If you fail to provide us with a **24-hour notice**, fail to show or cancel within the 24-hour notice, a $25.00 fee will be added to your account or one treatment shall be forfeited from any pre-paid package, including Groupon, Living Social or any other pre-paid packages types. A Credit Card/Debit Card number must be kept on file and will be charged accordingly. By signing below you acknowledge and agree to these term. With all teleHealth appointments, the practitioner will make three attempts in contacting you via the information you provided exactly 5 mins apart. If they are unable to contact you, this is considered a less than 24 hr notice cancellation. Please be available at the number you provided the day of your appointment.

RELEASE AND HOLD HARMLESS

I acknowledge that the services offered by Ekzotika Corp. d/b/a Cosmetic Laser Professionals Med Spa for treatments and other services, including, but not limited to, laser, aesthetics, massage, body sculpting, anti-aging hormonal therapy, IV Boost therapy, microdermabrasion, electrolysis, facials, photo facials, cavitation, cryotherapy (cryolipolysis), carboxytherapry, radio frequency, laser hair removal, tattoo removal, vein treatments, brown spot removal, Weight loss, BOTOX, DYSPORT, dermal fillers (Restylane, Juvederm, etc.), hormonal therapy and IV Boost are not an exact science and no specific or positive guarantees can or will be made as a result of receiving such treatments.

I understand that some patients may experience more change and improvements than others. In virtually all cases, multiple treatments are required in order to realize a difference and that each individual changes may vary. I understand that the amount of treatments needed to experience any change may need to be increased after my initial consultation and may require additional charges. I understand that the response to a treatment varies on an individual basis and that specific results are not guaranteed.

I also understand that the following risks and hazards may occur in connection with any particular treatment including but not limited to: unsatisfactory results, poor healing, discomfort, redness (1st degree burns), bruising, blistering, nerve damage, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risk can be known in advance.

Therefore, in consideration for any services or treatment received, I agree to hold harmless and release from liability Ekzotika Corp. and/or Cosmetic Laser Professionals Med Spa, Dr. Victor M. Estevez as well as any technicians, doctors, or employees and/or contractual vendors of the above companies for any condition or results, known or unknown that may arise as consequence of any treatment I receive.

Name:_____

Signature:_____

Ekzotika Corp DBA Cosmetic Laser Professionals Med Spa
8501 SW 124th Ave. Suite 212A Miami, FL 33184 www.CosmeticLaserProfessionals.com

Med Spa

CosmeticLaserProfessionals.com .

CREDIT CARD AUTHORIZATION FORM

Patient Name:_____ Date:_____

☐ One Time Charge: I authorize Cosmetic Laser Professionals Med Spa to withdraw the indicated amount from your account on or after the indicated date.

I _____ authorize Cosmetic Laser Professionals Med Spa to process a ___ payment of $_____ as of _____(Date)

☐ Recurring charge: I authorize scheduled periodic charge to my card. In each billing period, I will be charged the amount indicated below. You will be provided with a receipt for each payment and the charge will appear on your card or Bank Account Statement.

I _____ authorize Cosmetic Laser Professionals Med Spa to process a payment of $_____ as of _____(Date), and continue to charge on the same day of each following:

Weekly: ☐ Monthly: ☐

A copy of my Drivers license and payment method will be copied below to have payment processed by Cosmetic Laser Professionals Med Spa. This form will be signed and scanned in my file.

Good/Services Provided: _____

Card holder Name: _____

Card Type:_____

Account Number:_____

Expiration Date:_____

CVV:_____

Billing Address: _____

Zip Code:_____

Signature:_____ Date:_____

Ekzotika Corp DBA Cosmetic Laser Professionals Med Spa
8501 SW 124th Ave. Suite 212A Miami, FL 33184 www.CosmeticLaserProfessionals.com

I have answered the above questions to the best of my knowledge and understand that this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/ health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold Ekzotika Corp. d/b/a Cosmetic Laser Professionals Med Spa, Dr. Victor M. Estevez, together with its affiliates and their respective officers, directors, agents, employees, vendors, successors and assigns responsible from any and all claims and actions whatsoever arising from or relating to for any errors or omissions that I have made on this form.

Signature _____ Date _____

CANCELLATION/APPOINTMENT POLICY & SPA CHECK- IN

A 24-hour notice is REQUIRED for any rescheduling or cancellation of your appointments. If you fail to provide us with a 24-hour notice, fail to show or cancel within the 24-hour notice, a $25.00 fee will be added to your account or one treatment shall be forfeited from any pre-paid package, including Groupon, Living Social or any other pre-paid packages types. A Credit Card/ Debit Card number must be kept on file and will be charged accordingly. By signing below you acknowledge and agree to these terms.

Credit Card information provided above will be used for the cancellation policy.

Ekzotika Corp DBA Cosmetic Laser Professionals Med Spa
8501 SW 124th Ave. Suite 212A Miami, FL 33184 www.CosmeticLaserProfessionals.com

Med Spa
Cosmetic Laser Professionals

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Florida law, and not by a lawsuit or resort to court process except as Florida law provides for judicial review, of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use arbitration.

Article 2: All claims Must Be Arbitrated: It is. the intention of the parties that this agreement shall cover all claims or controversies whether in tort. contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician ") to a patient, including any Spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother' expected child or children.

Filing by Physician of an action in a court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names. addresses and telephone number of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a Florida superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure§§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if
not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision (s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Florida law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIA.L SEE ARTICLE I OF THIS CONTRACT.

By: Victor M. Estevez
Physician's or Duly (Date)
Authorized Representative Signature

By: Dr. Victor M. Estevez and/or representative practitioner .
Print or Stamp Name of Physician
Medical Group or Association Name

By: _____
Signature of Translator (if applicable) (Date)

By: _____ .
Print Name of Translator

By: _____ .
Patient's Signature

_____ .
Print Patient's Name

By: _____ .
Patient's Representative's Signature(if Applicable) Date: _____ .

_____ .
Print Name and Relationship to Patient