Do you know what we have to offer at our medical spa?

Please circle anything that interests you; we would love to tell you more about it!

bodyrxlouisville.com

Body Treatments
Massage
Body Polish
Back Treatments

Skin Care Products
Glo Therapeutics
Glo Minerals
ZO Skincare
Latisse

Facial Treatments
Lash & Brow Tinting
Chemical Peels
Customized Facial
Laser Facial
Microblading
Eyelash Extensions
Permanent Lip Tint
Laser Skin Tightening

Injectables
Botox
Dermal Fillers
PDO Threading

Vein Treatments
Laser Spider Vein Removal
Sclerotherapy

Weight Management
Medical Weight Loss Program
Ultra Burn Lipo Injections
B12 Injections

Hair Removal
Facial Waxing
Threading
Laser Hair Removal

Do you have any skin concerns? Yes or No
How would you like for us to contact you? Text______ Call______ Email______

Free Consultation? __________

Client Name: ______________________ Client Signature: __________________________

Date: _____________________

Refund Policy

BodyRx offers NO refunds or exchanges on any products or services.

Financial Policy

All services require payment prior to services being rendered. Insure you have correctly answered the prescreen questions if you are a weight loss client to avoid paying for a service you do not qualify for.

NO CHECKS, NO HEALTH SAVINGS ACCOUNT, NO FLEXIBLE SPENDING ACCOUNTS

Tardiness

Appointment times for massage are as scheduled and cannot extend beyond the stated tie to accommodate late arrivals. Please be on time for your appointment.

If arrival is delayed for spa services, we will make every effort to accommodate your appointment, but this is not always possible. Service time may be abbreviated to avoid delays for other guests as treatments are charged at the full value. Appointments missed by 15 minutes or more are cancelled with a 100% spa credit for the treatment amount missed, which is yours to use once your treatment is rescheduled.

Sickness

Massage/Bodywork is not appropriate care for infectious or contagious illness. Please cancel or reschedule your appointment as soon as you are aware of an illness.

Cancellation Policy

BodyRx and Dr. Nair enforce a 24-hour cancellation policy for ALL appointments. In order to reschedule your appointment, you must notify BodyRx at (502) 882-8680 or (502)974-3447; 24 hours before your scheduled appointment time to avoid being charged a $35 cancellation/no show fee. If I fail to show up to my scheduled appointment or cancel within 24 hours, I hereby authorize BodyRx to initiate entries to my debit/credit card account that is on file. If I do not have a card saved on file, I understand that I will receive a bill and that the fee must be paid prior to scheduling another appointment.

______________________________ __________________________

Signature Date

If yes, please explain: ____

I hereby state that the above medical history is, to the best of my knowledge, accurate and complete. If I ever have any changes in my health, or my medications change, I will inform the doctor at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

______________________________ ______________________

Signature Date

Discounts

We offer a 10% discount to those who are employed by the following companies: Ford Motor Company, JCPS, Humana, UPS, (GE) General Electric, and Military. This discount applies to all Spa services, but not the Medical Weight Management program or any products. Not to be combined with any other offers or promotions.

General Photography Release

I hereby authorize BodyRx/Riverside Medical, hereafter referred to as "Company," to publish photographs taken of me, for use in the BodyRx's print, online and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless BodyRx from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release BodyRx, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization

Printed Name: ______________________________ Date: ________________________

Signature: ______________________________

Street Address: ____

City: __________________ State: __________________ Zip: ______________________

Please answer the following questions:

Experience easy bruising/bleeding or excessive bleeding requiring special treatment? **Yes No**

Have you ever had Bioalcamide (permanent filler) injected anywhere in your face? **Yes No**

Do you or any family members suffer from the following neurological disorders:

Myasthenia Gravia **Yes No**

Eaton Lambert Syndrome **Yes No**

Do you smoke? ____________ Amount/Week? ____________

Do you drink? ____________ Amount/Week? ____________

Date/Type last drink: ______________________________

Are you currently pregnant? **Yes No**

Circle any of the following which you presently have or have had:

HIV/AIDS	Herpes/Cold Sore	Broken Capillaries
Skin Sensitivities	Rosacea	Acne
Cancer	Migraines/Headaches	Anemia
Diabetes	Seizures/ Epilepsy	Jaundice
Heart Trouble	Stroke	Arthritis
Angina	Lupus	Warts
Emphysema	High Blood Pressure	Pace Maker
Tuberculosis	Heart Murmur	Hepatitis
Asthma	Rheumatic Fever	Liver Disease
Thyroid Disease	Mitral Valve Prolapse	Stomach Ulcer
Hirsutism	Kidney Disease	Fainting Spells
Sinus Trouble	Glaucoma	Skin Conditions
Metal Implants	Keloids	Blood Disorders
(Including IUD)	(Excessive Scarring)	(bleeding/clot)
Blood Transfusion	Aspirin/Blood Thinner	Sickle Cell
Addictions	Artificial Valve	Artificial Joint
Alcoholism	Prosthesis	Oral Corticosteroids Cardiac Pacemaker
Dental Procedures	Psych Treatment	Eczema

Do you have or have had any other health problems not listed on this form? **Yes No**

Have you ever had an allergic reaction to any of the following?

Sulfer/Sulfa	Latex	Witch Hazel	Tea Tree
Grapes	Citrus	Fish/Marine/Iodine	Skin Allergy
Milk	Aspirin	Apples	

If yes, please explain: ______________________________

Please list all medications currently being taken:

____

Have you had any of the following in the last 14 days?

Facial Cosmetic Surgery	Botox Injections	Dermal Fillers
Light Treatments	Laser Resurfacing	Laser Treatments
Microdermabrasion	Other: ____________________	

Any problems with any of the listed procedures? **Y** **N**

If yes, please explain: ______________________________

What topical medications or creams are you currently using? Retin A? Others?

____

Have you ever used Accutane?	**Yes No**
Do you currently have a sun burn?	**Yes No**
Do you go to the tanning salon?	**Yes No**
Do you form thick raised scars from cuts or burns?	**Yes No**
Have you ever had a chemical peel or enzyme peel?	**Yes No**
Do you have hyperpigmentation/hypopigmentation after a physical injury?	**Yes No**
Have you ever had a laser procedure?	**Yes No**

If yes, what area? ______________________________

How long ago? ______________________________

Female Patients Only:

Are you pregnant?	**Yes No**	Brown Patches?	**Yes No**
Breast Feeding/Nursing?	**Yes No**	Birth Control?	**Yes No**
Menopausal?	**Yes No**	Last Menstrual Cycle? ______________	
Irregular Periods?	**Yes No**		

Patient Consult and History Form

Date: ________________

Name: ______________________ Date of Birth: _____________

Address: ____

City: ________________ State: ___________ Zip Code: ____________

Cell Phone: _____________________ Wireless Provider (for confirmations): __________

Do we need to be discreet with messages? **Y** **N**

Email Address: ____

How did you hear about us? ___________________________________

Emergency Contact Information

Name: ___________________________________

Relation: _________________________________

Phone: ___________________________________

Primary Physician Name: ______________________

Primary Physician Address: ____________________