HERMANN AESTHETICS
& WELLNESS

www.doctorhermann.com

3040 W. Cypress Street, Suite 103 Tampa, Florida 33609
6387 Central Avenue, St. Petersburg, Florida 33710
Phone (813) 902-9559 (727) 278-3992 Fax (813) 315-6611
Contact@DoctorHermann.com

REGISTRATION

PLEASE PRINT

Name:_____ **Date of Birth:**_____ **Age:**_____

Address:_____ **Marital Status: M S D W**

City:_____ **State:**_____ **Zip:** _____

Home Phone: ( )_____ **Employer:** _____

Work Phone: ( )_____ **Ext.**_____ **Occupation:**_____

Cell Phone: ( )_____ **Student: ( ) Yes ( ) No ( ) Fulltime ( )Part time**

E-Mail Address: _____ **Primary Care Physician:** _____

How did you hear about us: Family/Friend /Dr./ Yellow Pages / **Primary Care's Phone: ( )** _____

Other: _____ **Pharmacy:**_____

Pharmacy Phone : ( ) _____

EMERGENCY CONTACT

Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Home Phone: ( )_____

Work Phone: ( )_____

Relationship: _____

INFORMATION ON SPOUSE/PARENT

Name:_____

Employer:_____

Occupation:_____

Phone Number: ( ) _____

Date of Birth: _____

By providing an emergency contact and your spouse/parent information above, you hereby consent to the disclosure of your health information to such individuals as necessary to provide services to you, notify individuals in the event an emergency, and/or to follow-up on billing matters. You agree to notify Hermann Wellness if any of the information contained on this form changes. You further acknowledge and agree that you are financially responsible for any and all service provided by Hermann Wellness. A copy of this signature is as valid as the original.

PATIENT/GUARDIAN SIGNATURE:_____ **Date:** _____

Printed Name:_____ **Relationship to Patient**:_____

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PATIENT COMMUNICATIONS FORM

Telephone number for messages: ( )_____

Please indicate below how we may contact you and what information we may disclose. By selecting below, you hereby specifically consent to Hermann Wellness contacting you and disclosing your health information in the following ways:

_____ May we leave a message for an appointment reminder?
_____ May we leave a message on your answering machine, which may include personal and health information?
_____ May we leave a message with your spouse/significant other or family member, which may include personal and health information? Please list the individual that is authorized to receive your personal and health information:_____
_____ May we discuss your medical records with your spouse/significant other or family member? Please list whom: _____
_____ I give permission for my photos to be taken for purpose of evaluating treatment effectiveness for office use (only).

SIGNATURE:_____ **DATE:** _____

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Text Messaging & Email Marketing Consent form

To sign up to receive text messages and/or email messages regarding promotions related to goods and services, third party services, and updates from Hermann Wellness, please sign complete the fields below.

_____ **Yes,** please send me text messages related to Hermann Wellness promotions, updates, services, and third party (including without limitation Biomedical Health Tampa ("BioStation") products and services offered by or with Hermann Wellness at the following:
CELL PHONE NUMBER: _____
**By providing a cell phone number above, you specifically agree to receive text messages that relate to the marketing of products, goods, and/or services at the telephone number provided information and understand that such communications may be generated by an auto-dialer. These communications may incur charges from your telephone service providers, and you agree to be contacted in this fashion.*

_____ **Yes**, please send me electronic messages (emails) related to Hermann Wellness promotions, updates, services, and third party (including without limitation Biomedical Health Tampa ("BioStation") products and services offered by or with Hermann Wellness at the following:
EMAIL ADDRESS: _____
***By providing an email address above, you agree to receive email messages related to the marketing of products, goods and/or services and understand that using any unsecure electronic communication (such as regular email) to communicate with us can present risks to the security of information. These risks include possible interception of the information by unauthorized parties, misdirected emails, shared accounts, message forwarding, or storage of the information on unsecured platforms and/or devices.*

_____ **No** thanks, I do not want to hear about offers and services through text messaging or email.

Terms & Conditions:
This consent is affiliated with Anne Hermann, M.D., P.A. Should you choose to opt-in, you may receive up to 4 texts per month. Text messages will contain monthly specials and announcements. If you would like to **opt-out of this service, please check the box marked "No" above, and/or reply "STOP" to 797979. Message and Data Rates may apply. Your contact information will not be shared with third parties. Please contact Hermann Wellness (813) 902-9559, (727) 278-3992 for further assistance.
Privacy Policy:
**If you would like to view our privacy policy, please ask a staff member to provide you with a copy. An electronic copy is also available on the Hermann Wellness website.

I have the above Terms & Conditions and Privacy Policy, and agree to the terms provided herein.

SIGNATURE:_____

DATE: _____

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YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM
INITIAL PATIENT VISIT

Patient Name_____Date of Service_____Age_____

Please state your reason for coming in today. List any current concerns / complaints regarding your health.

_____

_____

PAST MEDICAL HISTORY	CURRENT MEDICATIONS

LIST ANY ALLERGIES TO MEDICATIONS	Please list any SURGICAL PROCEDURES that you have had.

FAMILY HISTORY
Please list any illness that the following relatives have:
Mother
Father
Sister(s)
Brother(s)
Grandparents
Aunts and uncles

Name_____Date of Service _____

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SOCIAL HISTORY		
Do you smoke?	If so, how many packs per day?	
Do you drink alcohol?	If so, how many per day?	How often?
Do you drink caffeine?	What kind?	How often?
What do you do for a living?		
Do you exercise?		

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- ☐ Changes in vision
- ☐ Headaches
- ☐ Jaw Pain
- ☐ Difficulty swallowing
- ☐ Mass or lump in neck
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ Cough
- ☐ Abdominal Pain
- ☐ Nausea or vomiting
- ☐ Diarrhea or constipation
- ☐ Skin rash
- ☐ Atypical mole or other skin lesion
- ☐ Weakness in legs, arms, hands, or feet
- ☐ Shooting pain in back, legs, arms or neck
- ☐ Muscle soreness
- ☐ Gum bleeding?
- ☐ Difficultly urinating?
- ☐ Difficulty sleeping?
- ☐ Depression, anxiety or memory loss
- ☐ Decreased libido?
- ☐ Women only: Please list date of last Pap smear and mammogram
  - ☐ Vaginal dryness ☐ Hot Flashes
  - ☐ Irregular periods ☐ Breast lumps or tenderness
  - ☐ Painful periods

Please describe any other complaints not covered in the list:

_____

_____

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CONSENT FOR TREATMENT & FINANACIAL POLICY

Patient Name: _____ **Date of Birth:** _____

CONSENT TO TREAT: I request and give consent to the employed and contracted providers of Anne Hermann, M.D., P.A. ("Hermann Wellness") (which includes without limitation, Anne Hermann, MD, Robin McClain ARNP, Michelle Roman PA-C, Mandy Brown LE) to provide and perform medical/surgical/acupuncture treatments, tests, procedures, prescribe and administer medications and other services and supplies as are considered necessary or beneficial for my health and wellbeing in the professional judgment of my provider. I understand that I have the right to refuse any procedure or treatment, and to discuss all medical treatments with my provider.

TREATMENT SERVICES & RISKS: I understand that the rendering of medical care (including without limitation, treatment, evaluations, and aesthetic procedures) is not an exact science and no representations, warranties, or guarantees have been given to me (or relied upon by me) by anyone as to the results or outcomes that may be obtained from examinations, treatments, procedures, or other healthcare services provided or recommended to me by Hermann Wellness or its providers. Medical treatment, procedures, and aesthetic care carry risks. Responses to treatment, procedures, medications, and services will vary from person to person and I understand that no guarantees can be made related to the response I will have to a specific treatment, procedure, or medication. There is a possibility that the treatment I receive may result in aggravation of existing symptoms and/or may cause pain or injury. I agree to communicate with my provider throughout your treatment to ensure the best treatment outcomes possible. I understand that I have the right to decline any part of my treatment at any time before or during treatment, should I feel any discomfort or pain or have other unresolved concerns. I understand that I may ask my provider about the treatment they have recommended and discuss the potential risks and benefits involved. By signing below, I acknowledge these risks and agree to inform my provider about any prior injury and/or any adverse effects I believe to be related the treatment you receive.

CONSENT TO THE DISCLOSURE OF HEALTH INFORMATION. To facilitate the treatment services provided pursuant to this consent and to coordinate care, I hereby authorize and request that copies of my medical/health records be provided to Hermann Wellness, and authorize Hermann Wellness to disclose my health information to outside health care providers providing treatment services to me. I understand that Hermann Wellness, its business associates, any provider, and/or any company providing reimbursement for services provided to me may obtain, use and/or disclose my health information for the purposes of treatment, payment and health care operations. This includes without limitation, all medical records, complete plans of treatment, progress summaries, treatment notes, including without limitation mental health information and diagnosis, HIV/AIDS and/or other STD information, substance use or abuse information, genetic information, and any other appropriately related documents or information reasonably requested to facilitate providing treatment to me or payment for the goods and services provided to me.

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. By signing below, I acknowledge these obligations and agree that I am the responsible party. I will make timely payments to Anne Hermann, MD. PA. for the services rendered. In the case of a default payment, to the extent permissible by law, I promise to pay any legal interest on the balance due, together with collection costs and reasonable attorney fees incurred to effect collection of this account and future outstanding accounts. If I fail to notify the office of a cancellation of an appointment within 24 hours of that appointment, I understand that I will be responsible for the full payment of the cancellation fee specified below.

NON-PARTICIPATION IN INSURANCE: Hermann Wellness and its providers do not accept health insurance and will not file any claims against health insurance policies or plans for reimbursement for the costs of services provided. Payment is due at the time of service. A list of charges for services is available upon request. Hermann Wellness will provide a good faith cost estimate for the services to be provided to by Hermann Wellness.

NOTICE TO MEDICARE PARTICIPANTS. Hermann Wellness does not accept Medicare or Medicare assignment rates and providers at Hermann Wellness have opted-out of Medicare. **IF YOU ARE ENROLLED AS A MEDICARE OR MEDICARE ADVANTAGE BENEFICIARY (REGARDLESS OF WEHTER MEDICARE IS YOUR PRIMARY OR SECONDARY INSURANCE), OR IF YOU WILL BECOME A MEDICARE OR MEDICARE ADVANTAGE BENEFICIARY DURING THE COURSE OF YOUR TREATMENT, THEN YOU MUST NOTIFY OUR STAFF AND COMPLETE A MEDICARE PRIVATE CONTRACT FORM.**

INITIALS: _____

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CANCELLATION POLICY: Hermann Wellness requests that a credit card number be provided to hold appointments. In the event that the patient does not show, or cancels an appointment with less than 24 hours' notice, Hermann Wellness reserves the right to charge a $75 cancellation fee for each missed appointment (the "Cancellation Fee"). By providing a credit card number and signing below, I hereby authorize Hermann Wellness to process the Cancellation Fee in accordance with this section. I represent and warrant that I am an authorized user of the credit card provided to Hermann Wellness, with full rights to the account and to agree to the processing of such Cancellation Fee.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE REVIEWED THE ABOVE, HAD AN OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED, AND THAT I AM VOLUNTARILY CONSENTING TO SERVICES TO BE RENDERED TO THE PATIENT (IDENTIFIED ABOVE) BY ANNE HERMANN, M.D., P.A., AND ITS PROVIDERS.

This document is effective for one year from the date of signature below.

PRINTED NAME: _____

RELATIONSHIP TO PATIENT (IF NOT PATIENT): _____

SIGNATURE: _____ DATE: _____

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PATIENT AUTHORIZATION FOR DISCLOSURE OF PHOTOS, VIDEOS AND RECORDINGS

This form says that you, the patient, authorize Anne Hermann, M.D., P.A. d/b/a Hermann Aesthetics and Wellness (the "Practice") to photograph, film or otherwise record you for marketing purposes and to disclose such images as you specify below.

Patient Name:_____ Date of Birth: _____

I authorize photos, videos and recordings to be taken of me or my child (or person for whom I am legal guardian) and specifically authorize the Practice to disclose such images of the patient as follows:

☐ Journals, academic publications, or other educational materials
☐ Other marketing publications/treatment outcome examples in electronic or paper form
☐ Social media sites, websites and/or other electronic forums
☐ All of the above
☐ Other: _____

I consent to the patient being photographed or recorded and to the disclosure of images of the patient for the above purposes. I understand that by authorizing the disclosure of images, the images may be seen by members of the general public for marketing purposes including website marketing, newspaper, social media, radio and television advertising. I understand that it is possible that someone may recognize me/the patient. I acknowledge that the Practice is the sole owner of all rights in, and to, the photos, videos, and recordings, in whatever format they are in. The Practice has the right, among other things, to edit and otherwise alter the photos, videos, and recordings, as deemed needed or desirable. I intend that this authorization apply to any photos, videos, and recordings that were taken or used by the Practice prior to the date of my signature below. I understand I will receive no compensation for the Practice's use of the photos, videos, and recordings.

This authorization is voluntary. Refusal to sign this authorization will not lead to an impact on my treatment, or refusal by my provider to provide treatment services to me. The Practice has the right to use and reproduce the photos, videos, and Recordings in media of whatever form, unless otherwise specified above, until the images are no longer needed for the purposes identified above unless I revoke this authorization. I may revoke this authorization by submitting my request in writing to the Practice but understand that such revocation will not apply to actions already taken by the Practice prior to my revocation and will not apply to publications of materials made prior to my revocation. I also understand that once images are disclosed based on this authorization, they may be further used or disclosed and will no longer be protected by state or federal privacy laws.

Expiration Date: _____ (50 years from the date signed below unless otherwise indicated)

By signing this from below, I confirm that this authorization has been explained to me in terms which I understand.

Signed: _____ Date: _____
(patient or representative)

_____ Telephone Number _____
(relationship to patient if not patient)

For individuals/representatives acting on behalf of the patient, you must indicate your relationship to the patient above.