Welcome to Goco Center for Aesthetics, a physician directed medical spa that blends science with beauty.

Goco Center for Aesthetics offers a team approach to enhancing your skin's health and reducing the signs of aging. This approach combines cutting edge technology and innovative skincare and treatments that enhance your skin's health and assist you in your desire to age gracefully.

As you become acquainted with our staff and our services, you will discover that we offer an incomparable level of professionalism and experience. Each staff member is dedicated to our standard of service and we will strive to make your aesthetic visit a pleasant one. We look forward to talking with you about your aesthetic needs. Allow us to assist you in attaining the look that you desire.

On your initial visit, we ask that you complete the enclosed patient information forms and bring them with you to your appointment. This first consultation will allow you and Dr. Goco and/or our Licensed Aesthetician or Paramedical Skincare Specialist to assess your goals and plan them out if you choose.

Again, welcome to our practice and we thank you for choosing Goco Center for Aesthetics for your skin's health. We look forward to serving you. Please visit our website at: www.GocoFaceMd.com and "like" us on Facebook.

Sincerely,

Paul E. Goco, MD
Gail Simms, Licensed Aesthetician
Kim Johnson, Paramedical Skin Care Specialist
Cherillyn Maddox, Cosmetic Patient Coordinator
Patty Bennett, Aesthetic Patient Coordinator

## GCA - PRIVACY NOTICE

# Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to the patient, and “Practitioner” refers to
GOCO CENTER FOR AESTHETICS. (GCA)

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis, diagnosis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Practitioner is not required to agree to the restrictions that I may request. However, if Practitioner agrees to a restriction that I request, the restriction is binding on Practitioner.

I have the right to revoke this consent, in writing, at any time, except to the extent that Practitioner has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Practitioner and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner. This Notice of Privacy Practices also describes my rights and duties of the Practitioner with respect to my protected health information.

Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

***May we contact you using more than one method?** Home #:__________________ Work phone #:_____________

Cell#:_______________________ email address__________________________________________________

****I have an ADVANCED DIRECTIVE Yes _________________ No**

***I give permission for the following individual (s) to speak with GCA regarding my:

***Treatment/condition*** † ***account information*** † ***scheduling information*** †

____________________________________________________________________________________

______________________________________________________________________________ Date:________________

Signature of Patient or Responsible Party Relationship

# Paul E. Goco, MD

Board Certified Facial Plastic Surgeon

**Gail Simms,** Licensed Aesthetician

**Kim Johnson,** Paramedical Skin Care Specialist

1370 Gateway Blvd., Suite 120

Murfreesboro, TN 37129

**615-848-9223**

**GocoFaceMD.com**


**Name**________________________________________________**DOB**____/____/____**SS#**____________________

Last First MI

**Address**_____________________________________________**City**______________**State**________**Zip**________

**Email**________________________________@__________________**Home Phone**(____)____________________

**Employer**_______________________________________________**Work Phone**(____)____________________

**Emergency Contact & Relation**_______________________________________________**Phone**(____)____________

**Gender** (Please circle)**:** Male Female **Marital Status**:_______ **Race**(optional):__________**Cell Phone**(_____)______________

**What Pharmacy do you use?** _________________________________**City**______________**Phone**______________

**How did you hear about our facility?** _____________________________________________________________

**Would you like to be added to our *email* mailing list?** Yes No
**If *No*, Would you like to be added to our mailing list?** Yes No

**FINANCIAL INFORMATION:**

We do not bill insurance companies for cosmetic or esthetic services because they are not "medically necessary". The initial consultation fee for Dr. Goco is $100.00. This fee will be applied to your first procedure that you schedule with him as long as you schedule within 60 day. The initial consultation fee for Aesthetic services is $50.00. This fee includes a 1 ½ hour Skincare evaluation with Complexion Analysis and/or Makeup Consultation and 1 complimentary follow up visit. Please note that this fee is non-refundable, even if you decide not to pursue cosmetic or esthetic services. Payment is expected at the time of visit. We accept cash, checks, Visa, MasterCard, American Express and Discover. All product returns require prior approval. Unopened, unused, and unmarked products may be returned for account credit within 30 days of purchase. Due to recent changes in product manufacturing restrictions, we will no longer be able to issue a credit for opened, used, or marked products.

_____________________________________________________ ______________________________

SIGNATURE DATE

**PHOTOGRAPH AUTHORIZATION**

I give my permission to Dr. Goco and the Goco Center for Aesthetics to take photographs of my treatment areas for diagnostic purposes and to document my response to treatments. I agree that these photographs are the property of Dr. Goco and the Goco Center for Aesthetics and I give my permission to use these photographs for teaching purposes, for use in scientific publications, books, journals, lectures, seminars, and electronic media. It is understood that in any such publication, I shall not be identified by name and that appropriate measures shall be made to protect my identity. I understand that I will not receive any compensation for the use of my photographs.

_____________________________________________________ ______________________________

SIGNATURE DATE

**Patient Name**____________________________________________ **Date**____________________

**YOUR HEALTH**
**Please list any major medical problems**_____________________________________________________________
_____________________________________________________________________________________________

**List all <u>prescribed</u> or <u>over the counter medications</u>, vitamins, herbal remedies, and topical medications**_________________________
_____________________________________________________________________________________________

**List any prior chemical peels, facial surgery, or other surgery with the date**_____________________________________________
_____________________________________________________________________________________________

**List any allergies you have to medicines, foods, skin care products, or environmental substances (mold etc.)** ____________________
_____________________________________________________________________________________________

**Are you currently using any prescription skin care?**_________________________________________________________

# <u>CONFIDENTIAL SKIN HEALTH QUESTIONAIRE</u>

(please print)

Kim or Gail

1. What is the reason for your visit today?_______________________________________________________________________
2. What special areas of concern do you have?____________________________________________________________________

## <u>EXPECTATIONS and HISTORY</u>

3. Which conditions would you like to improve?
   - Acne Scarring
   - Acne
   - Age spots
   - Enlarged pores
   - Fine lines & wrinkles
   - Pigmentation
   - Broken capillaries
   - Stretch marks
   - Surgical/facial scars
   - Other_____________________________________________________________________________________
4. How would you describe your skin?*(circle one)* **NORMAL/DRY/OILY/COMBINATION/SENSITIVE/ACNE PRONE/SUN DAMAGED**
5. How would you rate your skin? *(circle one)*
   - Always Burns, never tans
   - Burns easily, tans slightly
   - Burns moderately, tans gradually
   - Seldom burns, Always tans well
   - Rarely burns, Deep tan
   - Never burns, Deeply pigmented
6. Do you ever experience *(circle all that apply)* **FLAKINESS/TIGHTNESS/REDNESS/EXCESSIVE OILY SHINE DURING DAY**
7. What is your present skin regimen? *(product/brand/when used)*
   - Soap & water only____________________________________________________________________________
   - Cleanser_________________________________________________________________________________
   - Toner___________________________________________________________________________________
   - Masks/Scrubs______________________________________________________________________________
   - Moisturizer_______________________________________________________________________________
   - Exfoliation_______________________________________________________________________________
   - Sun block every day________________________________________________________________________
   - Make Up_________________________________________________________________________________
   - Other___________________________________________________________________________________

8. With your current or your potential new skin care regimen: *(circle one)*
   - How quickly do you need to see results? **QUICK/MODERATE/GRADUAL**
   - How much irritation can you accept? **NONE/LITTLE/MODERATE/PLENTY**
   - How much downtime can you tolerate? **NONE/ONE WEEK/2-3 WEEKS**

9. Are you ever exposed to chemicals, oils, or other caustic substances that may aggravate your skin? **YES/NO**

10. Do you blush easily? **YES/NO**
    If yes, what are the contributing factors? *(circle one)* **EMOTIONS/FOODS/TEMPERATURE CHANGES/OTHER**

11. Do you *(circle one)* **SUN BATHE/USE A TANNING BED**? HOW OFTEN?____________________

12. Have you ever had? *(circle all that apply)*

    **PEELS/MICRODERMABRASION/FACIAL SURGERY/COSMETIC SURGERY/BOTOX/COLLAGEN INJECTIONS/LASER RESURFACING**
    **HOW RECENTLY?**_______________

13. Are you under treatment for any current skin condition? **YES/NO**
    If yes, what?____________________________________________________________________________________________________

14. Does your skin heal? **FAST/SCARS/PIGMENTS**

15. Do you bruise easily? **YES/NO**

16. Skin History *( circle all that apply)* **HERPES (Cold Sores)/FEVER BLISTERS/BLEMISHES/ROSACEA/ECZEMA/PSORIASIS**

17. Have you ever used *( circle all that apply)* **ACUTANE/RETIN-A/RENOVA/TOPICAL ANTIBIOTICS/DIFFERIN/TAZARAC/AHA's**
    If yes, when and for how long?____________________________________________________________________________________

18. Any personal or family history of skin cancer? **YES/NO** Provide Detail_____________________________________________

19. How would you describe your overall health? **EXCELLENT/GOOD/FAIR/POOR**

20. Have you any of the following, past and/or present?

    - ACNE **YES/NO** WHEN______________
    - ALLERGIES **YES/NO**
    - ARTHRITIS or BURSITIS **YES/NO**
    - BLOOD PRESSURE **HIGH/LOW/NORMAL**
    - BREAST IMPLANTS **YES/NO**
    - CANCER **YES/NO**
    - CATARACTS **YES/NO**
    - CHOLESTEROL **HIGH/LOW/NORMAL**
    - CLAUSTROPHOBIC **YES/NO**
    - DIABETES **YES/NO**
    - DIARRHEA/CONSTIPATION **YES/NO**
    - ECZEMA **YES/NO**
    - EPILEPSY **YES/NO**
    - HAY FEVER **YES/NO**
    - HEADACHES **YES/NO**
    - HEART DISEASE/CONDITIONS **YES/NO**
    - HEPATITIS **YES/NO**
    - HIV/AIDS **YES/NO**
    - INFECTIONS **YES/NO**
    - LUPUS **YES/NO**
    - MENOPAUSAL **YES/NO**
    - METAL IMPLANTS **YES/NO**
    - PACE MAKER **YES/NO**
    - PHLEBITIS **YES/NO**
    - SERIOUS INJURY **YES/NO**
    - SLEEP PROBLEMS **YES/NO**
    - THYROID **YES/NO**
    - VARICOSE VEINS **YES/NO**
    - DO YOU SMOKE **YES/NO**
    - DO YOU WEAR CONTACT LENSES **YES/NO**

21. Have you ever had a reaction to? **COSMETICS/METALS/MEDICATION/FOOD/FRAGRANCE AIRBORNE PARTICLES/OTHER** Explain____________________________

22. **FOR WOMEN**: Oral Contraceptives? **YES/NO**
    - Are you pregnant or trying to get pregnant? **YES/NO**
    - Are you taking hormone replacement? **YES/NO**
    - Do you experience hormone imbalances? **YES/NO**

23. **FOR MEN**: Do you shave with? **Electric Shaver/Razor**
    - Do you experience skin breakouts? **YES/NO**
    - Do you have ingrown hair? **YES/NO**

## LIFESTYLE & DIET

1. Is your stress level? **HIGH/MEDIUM/LOW**
2. Do you normally sleep well? **YES/NO**
3. Do you regularly exercise? **YES/NO**
4. Do you have food intolerances? **YES/NO** What?________________________________________________
5. Do you follow any special diet? **YES/NO**
6. Daily water intake?__________________________________
7. How many cups of caffeinated beverage (coffee, tea, soft drinks) do you consume daily? **1-3 cups/ 4 or more**
8. In our treatment program, it may be necessary to recommend alterations to or additions to your in-home skin care regimen: Will this be OK with you **YES/NO**
9. **Do you smoke?** **YES/NO** How many? ________________________________________

Your aesthetician will recommend the appropriate schedule for future facial treatments or physician referral in order to achieve your skin improvement goals.