Third Circle Medical
PATIENT REGISTRATION FORM

Today's Date:	**Primary Care Provider:**

PATIENT INFORMATION

Patient's Last name:	**First:**	**Middle:**	**Marital status:**

Is this your legal name? ☒ Yes ☐ No	If not, what is your legal name?	Former name:	**Birth date:**	**Age**:	**Sex:** ☐ M ☐ F

Address:	**City:**	**State:**	**Zip:**

Social Security no.:	**Home phone no.:**	**Cell phone no.:**
Your Email:	**Your Employer:**	**Employer phone no.:**

Chose clinic because/referred to clinic by (Please choose one option): ☒ [Doctor's name] ☐ Friend

IN CASE OF EMERGENCY WHO WOULD YOU LIKE US TO CONTACT :

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

Patient or Guardian Signature **Date**

Third Circle Medical
MEDICAL HISTORY INFORMATION SHEET

NAME: ____ **AGE:** __________ **TODAY'S DATE:** _____________________

DATE OF BIRTH: (m/d/y) _____/_____/__________ **HEIGHT:** _____ **ft** _____ **inches WEIGHT:** _______________ **lbs**

REASON FOR TODAY'S EXAM: ____

HISTORY:

Past Surgical History: Surgery	Date	Past Medical History: Condition	Date

HISTORY OF SERIOUS INJURIES OR ILLNESSES: ☐ YES ☐ NO If yes, please describe: ________________________

____

COVID Vaccine: ☐ YES ☐ NO If yes, which one: ________________________ **Booster:** ☐ YES ☐ NO

Family History: (check all that apply and relationship to patient)

☐ Heart Attack__________ ☐ Cancer ___________ ☐ Colon Problems __________ ☐ Diabetes ___________

☐ Blood Pressure ________________ ☐ Other: ____

☐ None

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children How Many? ______

Tobacco Use: ☐ Never ☐ In the Past ☐ Currently: Type? ___________ How much? _________ How long? _________

Alcohol Use: ☐ Daily ☐ Occasional ☐ Never Other substance use or abuse? ☐ Yes ☐ No Type: ________________

Do you have allergies? ☐ Yes ☐ No ☐ Food ☐ Drug ☐ Latex ☐ Other: ___________

ALLERGEN	REACTION

Medications: List of Medications (including over-the-counter medications)

(If you have list, we can make a copy)

Medications	Dosage	Frequency

Your Pharmacy Name and Address: ____

Third Circle Medical
Cenchrea Lanier, MSN, ANP-BC,
1609 Rosewood Drive
Columbia TN 38401
Phone: 855-222-7938

Dear Patient,

You are being provided this letter of acknowledgment because you have requested that your doctor visit today be coded as "self-pay" and that you receive a "self-pay cash discount". A self-pay cash discount is offered to patients who elect to pay for the service in full on the date of service and who ***will not be submitting the claim to an insurance carrier***. You have requested that this service be coded as self-pay cash discount because **(initial one):**

____ You have **no** health insurance
____ You have health insurance but you will **not** be billed and instead want to pay out of pocket.
____ Cosmetic Procedure (Botox, Sclerotherapy, PRP Facial, PRP Injections)
____ Other Service (includes IV Wellness Infusions)
____ Other (please explain):
____

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- All fees for the self-pay cash discount service must be paid on the date of service.
- The self-pay cash discount amount covers only the professional services provided by your provider. You are financially responsible for all ancillary services, for example: laboratory, x-ray, or other services at Third Circle Medical not performed by your provider. You will receive a separate bill from the ancillary services.
- If you have insurance or other types of coverage, services today that are included in the "self-pay" cash discount will not likely be reimbursed by your carrier, or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the self-pay cash discount.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions.

I confirm that I am the patient, or the patient's duly authorized representative.

Patient Signature ____ Date: ________

If signed by someone other than the patient, please specify relationship to the patient:
____

Signature: _____________________________ ID#_______________________ Date: ________ Time: _________

NOT PART OF THE LEGAL MEDICAL RECORD

PRP (Platelet Rich Plasma) Informed Consent

Purpose & Background

Platelet Rich Plasma, also known as "PRP" is a treatment whereby a person's own blood is used to help fight the visible signs of aging skin. Platelets contain a concentrated amount of growth factors and these growth factors can help slow and even reverse some of the visible signs of aging by stimulating new collagen production. PRP can be injected and/or micro needled into the skin. When this is done it causes mild inflammation that triggers the healing cascade. During this process platelets release a number of enzymes and growth factors to promote healing. As a result, new collagen develops. Generally, 2-3 treatments are advised, however, more may be necessary for some individuals. Follow up treatments may be done approximately once a year after the initial group of treatments to help boost and maintain results.

The purpose of this consent form is to make you aware of the nature of the procedure and its risks so that you may decide if you would like to move forward with the treatment.

Alternative Treatments

Always remember that PRP treatments are elective treatments and that there are alternative treatments to consider, such as: No treatment, topical products, and different aesthetic procedures (chemical peels, BBL, micro-needling without PRP, etc.), dermal fillers and neurotoxin treatments, surgery.

Procedure

Pre-treatment – for the best results it is recommended to avoid any an@-inflammatory medications for 2 weeks prior to the procedure. This allows for increased platelet function and growth factor release.

1. Approximately 30cc of blood is drawn from the patient.
2. The tube(s) are then placed into a centrifuge where the blood is spun in order to separate the PRP from the red blood cells.
3. The PRP is then drawn up into syringes.
4. The PRP is then either injected into the skin by a Physician or RN and/or a Licensed Clinical Esthetician will micro needle the PRP into the skin. (See micro needling consent form for more detail)
5. When the PRP is injected just beneath the skin it is common to see unevenness in the treated area for up to a week. During this @me, you may even be able to feel lumps in the treated area.

Post-treatment – For the best results avoid an@-inflammatory medications for 1-4 weeks. Reduce physical activity and exercise for several days after the injections. Light exercise and normal daily activities are permitted.

<u>Risks/Discomfort</u>

Tenderness, bleeding, bruising, and infection as with any type of injection

Short lasting pinkness/redness of the skin

Swelling – apply ice pack as needed

Lumps/bumps in treated area or migration of PRP to adjacent areas

Asymmetry – The human face is normally asymmetrical in its appearance and anatomy. There can naturally be variation form one side of the face to the other in terms of the response to PRP.

Allergic response

Minimal effect from treatment

<u>Contradictions</u>

Pregnant

Abnormal platelet function or on anti-coagulation therapy

Cancer/Chemotherapy treatments

Acute and chronic infections

Chronic liver disease

Systemic use of steroids within the two weeks of the procedure

Most patients are pleased with the results of PRP treatments, however, like other cosmetic procedures, satisfaction is not guaranteed. Also, there is no guarantee that additional treatments will not be required to achieve the final result that the patient is looking for.

Consent

Benefits and risks of the procedure have been explained to me including alternative treatments. I have been provided with the opportunity to have any questions answered. I have read this consent and certify that I understand its contents in full. I have had enough @me to consider the information and I feel that I am sufficiently advised to consent to this procedure. I further agree to follow all pre and post treatment care instructions as directed. I hereby give my consent to this procedure.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Patient Name (please print):____ Date of Birth: _________________

Patient Signature:____Date:_________________________

Email Address (if you would like to be notified of specials, promotions, and events) ______________________________

Witness Name (please print):____

Witness Signature:____Date:_________________________