



CURRENT

Facial Plastic Surgery & Medical Spa

## NEW CLIENT INTAKE FORM

### Client's Information

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male

Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us?  FaceBook  Instagram  
 TikTok  Friend/Relative  
 Google Name: \_\_\_\_\_

### Consent and Agreement

**I consent to the services I am about to receive. I understand that ALL service fees will be charged to me, the client. I understand that I am responsible for all service costs.**

Client's Signature: \_\_\_\_\_ Parent/Guardian's Signature (if under 18): \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_

Please indicate if you ever had or suffered from the following medical conditions:

- |                                                |                                                                   |                                                    |
|------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Mental Illness        | <input type="checkbox"/> Dry Eyes                                 | <input type="checkbox"/> Hepatitis / Liver Disease |
| <input type="checkbox"/> Tuberculosis          | <input type="checkbox"/> Blood transfusion                        | <input type="checkbox"/> Nasal Obstruction         |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Sleep Apnea                              | <input type="checkbox"/> High Blood Pressure       |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Kidney Disease                           | <input type="checkbox"/> Double Vision             |
| <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> HIV                                      |                                                    |
| <input type="checkbox"/> Lung Disease / Asthma | <input type="checkbox"/> Depression                               |                                                    |
| <input type="checkbox"/> Nasal Trauma          | <input type="checkbox"/> Gastrointestinal problems                |                                                    |
| <input type="checkbox"/> Blurred Vision        | <input type="checkbox"/> Radiation therapy for<br>acne as a child |                                                    |

Could you possibly be pregnant?  Yes  No

Have you or a family member ever had a reaction to general anesthesia? If yes, please elaborate:

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Have you or a family member ever been diagnosed with a bleeding disorder?  Yes  No

Any drug allergies or sensitivities? If yes, please list them:  Yes  No

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**Please list all previous surgery, including cosmetic, serious illnesses, or hospitalizations, including childbirth:**

<b>Procedure/Hospitalization:</b>	<b>Year of procedure and type of anesthesia used (general/local):</b>
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Are you on any dietary supplements or suppressants? If yes, please list them:

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## Medication

**Please list all current medications, including dosages. Include all over the counter medicines, such as aspirin, vitamins, etc.**

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

**Any nicotine** in the past 3 months?  Yes  No

Cigarettes  Cigars  Pipe  Gum/Patch  Ecig/Vape

If yes, how much and how long? If you have quit, how long ago did you quit?

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Do you drink alcohol? If yes, how much and how often do you drink?  Yes  No

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Do you currently use or have you ever used:

- Cocaine  Intravenous drugs  Methamphetamines
- Marijuana or other smoked drugs  Afrin or other nasal sprays for longer than 2-3 days?
- None of the above

If yes, what, how long, and how recently?

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## Emergency Contact

Full Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## CLIENT PHOTOGRAPH AND VIDEO RELEASE FORM

**I understand that photographs and/or videos may be taken of me or parts of my body before, during, and after surgery. These images may be shared with staff, other physicians or health professionals, and members of the public for educational and marketing purposes. I hereby give my consent for Dr. Novis/CURRENT to use the photographs and/or videos under the following circumstances:**

Please initial **JUST ONE** of the following statements:

\_\_\_\_\_ I OPT OUT. I **do not** want my photographs and/or videos to be used for advertising or marketing. They will only be used for my medical chart.

\_\_\_\_\_ **ALL MEDIA EXCLUDING SOCIAL MEDIA:** Images and/or videos capturing me or specific parts of my body, along with information about medical treatments I've received, **may be utilized in various print or broadcast media formats.** These formats include newspapers, pamphlets, educational films, practice websites, and television, with the purpose of informing and educating the public or fellow physicians about plastic surgery.

\_\_\_\_\_ **PRACTICE WEBSITE ONLY:** Photographs and/or videos capturing me or specific parts of my body, along with information about medical treatments I've undergone, might be featured on our website. Personal information will not be disclosed to inform the public about plastic surgery techniques. I acknowledge that once these images are uploaded to a digital platform, they may be subject to alteration, archiving, permanence, and searchability.

\_\_\_\_\_ **ALL MEDIA INCLUDING SOCIAL MEDIA:** Images and/or videos capturing me or specific parts of my body, along with information regarding medical treatments I've undergone, may be utilized on various social media platforms, such as Facebook, Instagram, YouTube, Twitter, TikTok, and others. This usage aims to educate the public or fellow medical professionals about plastic surgery. I acknowledge that upon publication, I forfeit control and ownership rights over these images. Furthermore, I recognize that the respective social media platforms may acquire control and ownership rights over the published images. Additionally, I am aware that once images are posted online, they can be edited, stored, and are permanent and searchable.

Please check **JUST ONE** of the following statements:

I consent to the use of my full face in photos and/or videos

I consent to the use of cropped/zoomed-in photos and/or videos of my surgical location

**PLEASE REVIEW AND INITIAL EACH OF THE FOLLOWING:**

\_\_\_\_\_ I understand that this authorization expires 99 years from the date signed.

\_\_\_\_\_ I understand that my participation is voluntary. If I do not sign this form, my procedures and procedure cost **will not be affected**.

\_\_\_\_\_ I understand that I will NOT receive compensation for my participation.

\_\_\_\_\_ By signing this form, the personal health care information I relay or allow to be relayed to an outside source, such as a social media platform or news source, is no longer protected by state and federal privacy laws and may be re-disclosed by that source.

\_\_\_\_\_ Before signing this form, I have considered my decision carefully.

Client's Signature:

Parent/Guardian's Signature (if under 18):

\_\_\_\_\_  
Date: \_\_\_\_\_

\_\_\_\_\_  
Date: \_\_\_\_\_

Witness Signature

\_\_\_\_\_  
Date: \_\_\_\_\_



**CURRENT FACIAL PLASTIC SURGERY, LLC**  
**ARBITRATION AGREEMENT**

This Arbitration Agreement is executed by Dr. Sarah Novis and CURRENT Facial Plastic Surgery, LLC (also d/b/a CURRENT Medical Spa), individually and on behalf of its staff and employees (collectively, “CFPS”) and you (“Patient”). The parties to this Arbitration Agreement agree that any and all claims, disputes and controversies (collectively referred to as “claims”) arising out of, or in connection with, or relating in any way to any diagnosis, treatment, medical service, or spa service received, or goods purchased from NPS or any of its employees will be resolved exclusively by binding arbitration. This includes, but is not limited to, claims for payment, nonpayment, refunds, breach of contract, breach of privacy, fraud or misrepresentation, negligence, malpractice, claims for equitable relief or claims based on tort, contract, statute, or warranty. Should you initiate a claim, the parties agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Facial Plastic and Reconstructive Surgery. The parties agree that these physician experts will be obligated to adhere to the guidelines or code of conduct defined by the American Academy/Board of Facial Plastic and Reconstructive Surgery. The parties further agree to require any attorney hired by them to adhere to these provisions. Any arbitration conducted pursuant to this Arbitration Agreement shall be conducted by JAMS, an independent and impartial entity regularly engaged in providing arbitration services, in accordance with the JAMS Comprehensive Arbitration Rules and Procedures, which can be found at <http://www.jamsadr.com> (“Rules”). In the event of any inconsistency between this agreement and the Rules, the arbitrator shall apply the terms of this agreement. The parties acknowledge that this provision alters the Rules. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16. The parties agree that this Arbitration Agreement shall inure to the benefit of and binds the parties, their spouses, heirs, children, siblings, representatives, successors and assigns. The parties further intend that this agreement is to survive the lives or existence of the parties hereto. All claims based in whole or part on the same incident, transaction or related care or service provided by NPS to you shall be arbitrated in one proceeding. A claim shall be waived and forever barred if it arose and should reasonably have been discovered prior to the date upon which notice of arbitration is given to NPS and such claim is not presented in the arbitration proceeding. You have the right to seek legal counsel concerning this Arbitration Agreement. Execution of this Arbitration Agreement is not a precondition to the furnishing of services to you. In the event a Court having jurisdiction finds any phrase, clause, sentence or provision of this Arbitration Agreement unenforceable, the remainder of the agreement shall be enforceable. The parties acknowledge and understand that arbitration is a complete substitute for traditional litigation and by entering in to this agreement the parties are giving up and waiving their constitutional right to have any claim decided in a court of law before a judge and a jury, as well as any appeal from a decision or award of damages. Patient certifies that he/she has read this Arbitration Agreement and understands its contents.

**THIS CONTRACT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES**

Client’s Signature:

Sarah Novis, M.D.’s Signature:

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Date: