Laser Vein Center
Thomas Wright MD RVT

Demographics

Patient Name:_____

Address: _____

City, St, Zip _____

Primary Phone: _____ Alternate: _____

DOB: _____ Social Security #: _____

Marital Status: ☐ Married ☐ Single ☐ Other
Emergency Contact:_____ Emergency #: _____ Relationship:_____

Employer/ School _____ Occupation: _____

Which number would you prefer us to leave a message: Home____ Cell ____ Work ___
Do we have your permission to send you a birthday card, a holiday card or perhaps a newsletter to your
Home ____ Email ____

Email: _____

Referring Source: _____

Family Doctor _____ Phone # _____

Are you currently being treated by any other physician(s)?
☐No ☐Yes *(If Yes; Please list with phone number)*
_____

List of Medications (below)	Dosage	How Often Taken

Name of Pharmacy _____Phone # _____

List ALL Allergies _____

Surgeries & Dates:

_____

_____

_____

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Mark any of the following conditions you or a family member has EVER experienced?

Condition	Self	Family	Please Explain
Sinusitis	☐	☐	_____
Hypothyroidism	☐	☐	_____
Skin cancer	☐	☐	_____
Abnormal moles	☐	☐	_____
Psoriasis	☐	☐	_____
Eczema	☐	☐	_____
Hives	☐	☐	_____
Asthma	☐	☐	_____
COPD	☐	☐	_____
Lung cancer	☐	☐	_____
Pneumonia	☐	☐	_____
Atrial fibrillation	☐	☐	_____
Murmur	☐	☐	_____
Angina (chest pain)	☐	☐	_____
Ankle swelling	☐	☐	_____
Heart attack	☐	☐	_____
High blood pressure	☐	☐	_____
Rheumatic/Scarlet fever	☐	☐	_____
Gastric reflux (GERD)	☐	☐	_____
Gastric bleeding	☐	☐	_____
Colon cancer	☐	☐	_____
Prostate/cancer enlargement	☐	☐	_____
Testicular cancer	☐	☐	_____
Pinched nerve	☐	☐	_____
Spinal stenosis	☐	☐	_____
Stroke/seizures/TIA	☐	☐	_____
Diabetes (type)	☐	☐	_____
Breast cancer	☐	☐	_____
Anemia	☐	☐	_____

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Are you pregnant? ☐No ☐Yes Number of Pregnancies _____Number of Births _____

Decreased appetite	☐ No ☐ Yes
Change in weight	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes
High cholesterol	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes
Fevers	☐ No ☐ Yes
Cancer	☐ No ☐ Yes
Decreased vision	☐ No ☐ Yes
Double vision	☐ No ☐ Yes
Temporary blindness	☐ No ☐ Yes
Blurred vision	☐ No ☐ Yes
Detached retina	☐ No ☐ Yes
Temporal arteritis	☐ No ☐ Yes
Paralysis	☐ No ☐ Yes
Weakness	☐ No ☐ Yes
Seizure	☐ No ☐ Yes
Fainting	☐ No ☐ Yes
Headache	☐ No ☐ Yes
Migraine	☐ No ☐ Yes
Stroke	☐ No ☐ Yes
Numbness in limbs	☐ No ☐ Yes
Slurred speech	☐ No ☐ Yes
Decreased memory	☐ No ☐ Yes
Ankle swelling	☐ No ☐ Yes
Atrial fibrillation	☐ No ☐ Yes
Labored breathing	☐ No ☐ Yes
Dizziness	☐ No ☐ Yes
Congenital heart dis.	☐ No ☐ Yes
Rheumatic heart dis.	☐ No ☐ Yes
Murmur	☐ No ☐ Yes
Loss of consciousness	☐ No ☐ Yes
Palpitations	☐ No ☐ Yes
Chest pain	☐ No ☐ Yes
Chest discomfort	☐ No ☐ Yes
Unable to urinate	☐ No ☐ Yes
Painful urination	☐ No ☐ Yes
Prostate problems	☐ No ☐ Yes
Kidney/bladder dis.	☐ No ☐ Yes
Decr. urine stream	☐ No ☐ Yes
Kidney failure	☐ No ☐ Yes
Blood in urine	☐ No ☐ Yes
Excessive urination	☐ No ☐ Yes

Anxiety	☐ No ☐ Yes
Confusion	☐ No ☐ Yes
Depression	☐ No ☐ Yes
Delusions	☐ No ☐ Yes
Easy bruising	☐ No ☐ Yes
Anemia	☐ No ☐ Yes
Clotting disorder	☐ No ☐ Yes
Bleeding disorder	☐ No ☐ Yes
Pain in leg at rest	☐ No ☐ Yes
Leg pain when walking	☐ No ☐ Yes
Slow healing leg wound	☐ No ☐ Yes
Sensitivity to cold	☐ No ☐ Yes
Arterial disease	☐ No ☐ Yes
History of gangrene	☐ No ☐ Yes
Change in moles	☐ No ☐ Yes
Itching	☐ No ☐ Yes
Rash	☐ No ☐ Yes
Dry skin	☐ No ☐ Yes
Chronic skin problems	☐ No ☐ Yes
Sore throat	☐ No ☐ Yes
Sinus drainage	☐ No ☐ Yes
Hoarseness	☐ No ☐ Yes
Discharge from ears	☐ No ☐ Yes
Nose bleeds	☐ No ☐ Yes
Hearing loss	☐ No ☐ Yes
Ringing in ears	☐ No ☐ Yes
Painful swallowing	☐ No ☐ Yes
Indigestion	☐ No ☐ Yes
Vomiting	☐ No ☐ Yes
Vomiting blood	☐ No ☐ Yes
Gall bladder problems	☐ No ☐ Yes
Liver disease	☐ No ☐ Yes
Hemorrhoids	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes
Jaundice	☐ No ☐ Yes
Constipation	☐ No ☐ Yes
Abdominal pain	☐ No ☐ Yes
Bloody stools	☐ No ☐ Yes
Change in stool color	☐ No ☐ Yes
Change in bowel habits	☐ No ☐ Yes

Cough	☐ No ☐ Yes
Respiratory pain	☐ No ☐ Yes
COPD	☐ No ☐ Yes
Prod. of sputum	☐ No ☐ Yes
Coughing blood	☐ No ☐ Yes
Apnea	☐ No ☐ Yes
Wheezing	☐ No ☐ Yes
Bronchitis	☐ No ☐ Yes
Pneumonia	☐ No ☐
Bone/joint deformity	☐ No ☐ Yes
Joint swelling	☐ No ☐ Yes
Back pain	☐ No ☐ Yes
Muscle aches	☐ No ☐ Yes
Limited motion	☐ No ☐ Yes
Knee replacement	☐ No ☐ Yes
Hip replacement	☐ No ☐ Yes
Spinal problems	☐ No ☐ Yes
Thyroid disorder	☐ No ☐ Yes
Diabetes w/ insulin	☐ No ☐ Yes
Diabetes -no insulin	☐ No ☐ Yes
Extreme appetite	☐ No ☐ Yes
Extreme thirst	☐ No ☐ Yes
Lupus	☐ No ☐ Yes
Rheumatoid arthritis	☐ No ☐ Yes

FEMALE ONLY

Irregular periods	☐ No ☐ Yes
Breast problems	☐ No ☐ Yes
Menopause	☐ No ☐ Yes
Last pelvic exam	_____ mo / year
Last period	_____ year

OFFICE USE ONLY

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Thomas Wright MD RVT

Habits

Do you drink alcoholic beverages? □No □Yes (*#/week* _____*)*

Do you now or have you ever used tobacco? □No □Yes *(Packs/week* _____*)*Quit Date, if applicable _____

Do you exercise regularly? □No □Yes (*#of days / week* _____*)*

Vein History

When did you first notice your enlarged or discolored veins?_____

Where are the veins you are seeking a medical opinion for located? ☐ Face ☐ Leg(s), (*Circle)* Right Leg / Left Leg / Both

Have you ever worn prescription grade compression stockings? ☐ No ☐ Yes, When and for how long?_____

Do you have a family history of vein problems? ☐ No ☐ Yes, What family member? _____

Please ☑ next to the symptoms that apply to you:

☐ Aching leg(s)	☐ Appearance	☐ Burning	☐ Cramps
☐ Dull Pain	☐ Heaviness	☐ Itching	☐ Leg Ulcers
☐ Restless Legs	☐ Sharp Pain	☐ Swelling	☐ Throbbing
☐ Tiredness	☐ Other: _____		

Phlebitis (Clot in surface veins in legs)? ☐ No ☐ Yes, When _____

Deep Vein Thrombosis (Clot in deep veins)? ☐ No ☐ Yes, When _____

Pulmonary Embolus (Blood clot in lungs)? ☐ No ☐ Yes, When _____

Bleeding from veins? ☐ No ☐ Yes, When _____

Have you had sclerotherapy before? ☐ No ☐ Yes, When _____

Venogram (Vein X-Ray) ☐ No ☐ Yes, When _____

Have you ever had vein surgery? ☐ No ☐ Yes, When _____

Hemorrhoids? ☐ No ☐ Yes, When _____

IV drug use? ☐ No ☐ Yes, When _____

AIDS/HIV/hepatitis? ☐ No ☐ Yes, When _____

Trauma/injury to your legs? ☐ No ☐ Yes, When _____

Clotting disorder? ☐ No ☐ Yes, When _____

I request that payment of authorized Medicare/third party insurers benefits be made either to me or on my behalf to Dr. Thomas Wright for any services furnished by me. I authorize any holder of medical or other information about me to release to the Centers of Medicare & Medicaid Services or third party insurer or their agents any information needed to determine these benefits or benefits for related services. I understand I am responsible for any balance not covered by my insurer.

_____ _____

Patient Signature Date

PROVIDER–PATIENT VOLUNTARY ARBITRATION AGREEMENT

Agreement to Arbitrate. The parties to this Provider–Patient Voluntary Arbitration Agreement ("Arbitration Agreement") are Thomas Wright MD and Laser Lipo and Vein Center/Lakeview Medical ("Provider"), and the Patient named below. It is understood that any dispute as to medical malpractice—that is as to whether any medical services rendered or that were failed to be rendered by the Provider or by any of Provider's agents, employees, associates, to the Patient were unnecessary or unauthorized, were improperly, negligently or incompletely rendered, or the failure to render such services was improper or otherwise negligent—will be determined by submission to arbitration binding upon the parties and not by a lawsuit or other resort to court or the judicial process except as state law provides for judicial review of arbitration proceedings. The parties recognize that, in Missouri, there is a right to appeal an arbitration award; however, unless there is evidence of fraud on the part of the arbitrator(s) or a serious procedural defect, an arbitration award pursuant to this Arbitration Agreement would not be overturned and would be a final award. The parties to this Arbitration Agreement, by entering into it, are waiving their constitutional right to have any such dispute decided in a court of law before a jury or before a judge and instead are accepting the use of arbitration as the appropriate and exclusive forum to resolve any dispute or controversy between them. **II. All Claims Must be Arbitrated**. It is the mutual agreement and intention of the parties that this Arbitration Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the Provider, including any spouse or heirs of the Patient, or any others making a claim on the Patient's behalf, and any children. The term "Patient" herein shall include that individual receiving medical treatment or advice and, where applicable, shall include both the woman patient and the woman's expected child or children. The term "Provider" herein shall include all of Provider's agents and employees. The parties mutually agree that they shall submit to binding arbitration all disputes (except actions by the Provider to collect a fee) against each other and their respective agents, partners, associates, employees, representatives, governing bodies, affiliates, insurers, attorneys, for all disputes arising out of or in any way related to or connected with the care and treatment of the Patient provided by the Provider, including but not limited to any disputes concerning alleged personal injury to the Patient caused by improper or inadequate care; allegations of medical malpractice; claims of loss of consortium, wrongful death and emotional distress; any disputes concerning whether any statutory provisions relating to the Patient's rights under Missouri law were violated; any claim for punitive damages; and any other dispute under Missouri or federal law based on contract, tort or statute, all of which shall be determined by submission to binding arbitration and not by a lawsuit or resort to judicial process except as state law provides for judicial review of arbitration proceedings. The filing of any action in any court by the Provider to collect any fee from the Patient shall not waive the right to compel arbitration of any other claim as described above. Following the assertion in court of any claim against the Provider, however, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration. **III. Procedures and Applicable Law**. A demand for arbitration under this Arbitration Agreement must be communicated in writing to all parties. Each party shall select an arbitrator ("Party Arbitrator") within thirty (30) days of such demand, and a third arbitrator ("Neutral Arbitrator") shall be selected by the appointed Party Arbitrators within sixty (60) days thereafter. In the event the two Party Arbitrators fail to select the Neutral Arbitrator within the sixty (60) day period, a third arbitrator will be appointed from a panel of five arbitrators supplied by Pinnacle Arbitration and Mediation Services, Saint Louis, Missouri 63108. Within thirty (30) days of the panel of five arbitrators being supplied, the parties will each strike two arbitrators on the panel according to the following procedure and the remaining arbitrator will be the Neutral Arbitrator. Either party shall have the right to request the state circuit court located in the county where the Patient resides or where the Provider's principal place of business is located to appoint a neutral arbitrator in the event that the method provided herein fails, and the court's selection shall be final and binding on the parties. Each party to the arbitration shall pay one hundred percent (100%) of the expenses and fees of its own Party Arbitrator and fifty percent (50%) of the expenses and fees of the Neutral Arbitrator as well as other expenses and fees of the arbitration, not including its own counsel fees or witness fees or other expenses incurred by a party for such party's own benefit. The arbitrators shall apply the laws of the State of Missouri, including the applicable statute of limitations and the limitation on damages applicable to medical malpractice cases against health care providers, which is found in Chapter 538 of the Revised Statutes of Missouri. The arbitration hearing will be held before a panel of three (3) arbitrators unless the parties agree otherwise. A decision by the majority of arbitrators hearing the case shall be the final decision of the arbitrators in the arbitration. Any party to the arbitration as set forth in this Arbitration Agreement may be represented by an attorney of his or her choice at his or her own expense. The arbitrators will hear the facts and reach a decision whether or not the parties are represented by an attorney. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action and upon such intervention or joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding or else waived. A claim shall be waived and forever barred if: (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable state

statute of limitations; (2) the Patient fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence; or (3) the Patient fails to raise all potential claims from the same incident, transaction or related circumstances to the arbitration proceeding. **Acknowledgements**. Upon signing this Arbitration Agreement submitting to binding arbitration all disputes or controversies arising out of the Provider's services provided to Patient, the Patient hereby acknowledges the following: The Patient, and/or his or her legal representative, understands that he or she has the right to consult with an attorney of his or her choice before signing this Arbitration Agreement. The Patient, understands, agrees to, and has received a copy of this Arbitration Agreement, has had an opportunity to ask any questions about this Arbitration Agreement and has entered into this Arbitration Agreement willingly. Each party agrees to waive the right to a trial, before a judge or jury, for all disputes (except actions by the Provider to collect a fee) as stated above, subject to the provisions of binding arbitration under this Arbitration Agreement. This Arbitration Agreement may be revoked by Patient upon written notice delivered to the Provider within thirty (30) days of the Patient's signature date, and if not revoked within that time frame, it will govern all claims regarding medical services involving Patient and Provider. The Patient, and/or his or her legal representative, acknowledges that he or she has read carefully each provision of this Arbitration Agreement and the Introduction to the Provider–Patient Voluntary Arbitration Agreement and has a received a copy of each. **Miscellaneous**. The original Arbitration Agreement is to be filed in Patient's medical records. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. Prior to signing this document, Patient may confer with Provider in order to request any change or modification to the provisions of this document. If Patient intends this Arbitration Agreement to cover services rendered before the date it is signed (for example, emergency treatment), Patient should initial below. Effective as of the date of first medical services. _____ Patient's initials. **The undersigned acknowledge that each of them has read this arbitration agreement and that by signing this arbitration agreement, each has waived his or her right to a trail before a judge or a jury, and that each of them voluntarily consents to all the terms of this agreement. This contract contains a binding arbitration provision which may be enforced by the parties.**

By: LaserLipoAndVein/Lakeview Medical Group : _____ Date_____

Patient_____ Date_____

Patient (PRINT NAME) _____

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your Protected Health Information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Use and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Results of tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission. We may use and disclose PHI about you so that the treatment and services you receive at our practice may be billed and payment collected from you, an insurance company or a third party. We may need to give your health plan information about treatment you received so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you regarding your appointments or send notification by mail of test results.
We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law; Public Health issues as Required by Law; Communicable Diseases; Health Oversight, Abuse or Neglect; Food and Drug Administration requirements; Legal proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

Workers' Compensation: We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object Unless Required By Law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your PHI.

You Have the Right to Inspect and Copy Your PHI: You have the right to inspect and copy your PHI that may be used to make decisions about your care. Usually, this includes medical and billing records, under Federal law; however, you may not inspect or copy the following records: psychotherapy notes, information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and Protected Health Information that is subject to law that prohibits access to PHI.
To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying (including labor), mailing, or other supplies associated with your request.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

You Have the Right to Request a Restriction of Your Protected Health Information: This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You Have the Right to Request to Receive Confidential Communications from us by Alternative Means or at an Alternative Location. You Have the Right to Obtain a Paper Copy of This Notice From Us upon request.

You May Have the Right to Have Your Physician Amend your Protected Health Information. If we deny your request for amendment, you have the right to file a Statement of Disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You Have the Right to Receive an Accounting of Certain Disclosures We Have Made, if any, of Your Protected Health Information. To request this list or accounting of disclosures, you must submit your request in writing. Your request must state a period, which may not be longer than six years and may not include dates prior to April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred. The accounting must be provided to you no later than 60 days after the receipt of your request, unless we utilize the 30-day extension period.

Changes to This Notice: We must change this Notice as necessary and appropriate to comply with changes in the law. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you as well as any information we receive in the future. We will post a copy of the current Notice at our practice. This Notice will contain, on the first page, in the top right-hand corner, the effective date. Upon request, we will provide you with the most recently revised Notice at any office visit.

Complaints:
You may complain to us or to the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a compliant with us by notifying our privacy contact at 314.397.4012 or with the Secretary of the Department of Health and Human Services at 200 Independence Avenue, SW, Washington, DC 20201. All complaints must be in writing. We will not retaliate against you for filing a compliant.

This notice was published and becomes effective onJuly 1, 2003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of, and provide individuals with, this Notice of our Legal Duties and Privacy Practices with respect to Protected Health Information. If you do have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

MEDICAL INFORMATION RELEASE

Do we have your permission to:

Leave a message on your answering machine at home? _____yes _____no
Leave a message on your cellular phone? _____yes _____no #_____
Leave a message at your place of employment? _____yes _____no
Discuss your medical condition with members of your family or anyone else? _____yes** _____no

**if yes, please list the name(s) of the people and their relationship to you. Please list your spouse and/or anyone who may call our office for you. If you do not list anyone, our doctors and office staff CANNOT discuss your medical information with anyone but you.

I, _____, give permission to be above doctors and/or staff to release information (verbal or written) about me, my medical condition and/or treatment to the following person(s).

NAME OF PERSON (please print)	RELATIONSHIP TO PATIENT
_____	_____
_____	_____

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____
Signature: _____ Date: _____

Office Use Only:
Our practice will make a good faith effort to obtain a written Acknowledgement of Receipt of the Notice provided to the individual. If written acknowledgment is not obtained, our practice must document its good faith efforts to obtain such acknowledgment and record the reason why the acknowledgment was not obtained.

Refused to Sign: _____ Physically Unable to Sign: _____
Other _____

Employee Signature:_____Date_____

07.01.03

PHOTOGRAPHY/VIDEOTAPING (FOR MEDIA OR EDUCATIONAL PURPOSES)

I hereby give my consent to have photographs, videotaped images, or other images made of myself and/or consent to interviews with a member of the news media or a representative of Laser Lipo and Vein Center. I understand and agree that these images may be used by the media or by Laser Lipo and Vein Center for the purposes of advertising and/or marketing.

_____	_____	_____	_____
Signature of Patient or Legal Representative	Date	Witness	Date