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Patient Intake

Name:_____ _____ _____ Today's Date:_____
(Last) (First) (Middle)

Date of Birth:_____ Age:_____ Home Phone:_____ Cell Phone:_____

Home Address:_____

City:_____ State:_____ Zip:_____

E-Mail Address:_____ Occupation:_____

May we contact you via Email or text? ( ) YES ( ) NO

In Case of Emergency Contact:_____Relationship:_____

Home Phone:_____Cell Phone:_____Work:_____

Who may we thank for referring you to our clinic?
☐ Google ☐ Social Media ☐ Word of Mouth ☐ A Happy Patient: _____

I want to unlock exclusive offers by subscribing to the monthly newsletter: Yes ☐ No ☐

What services are you currently interested in?

☐ Hair Restoration ☐ Body Contouring ☐ Hormone Replacement Therapy

☐ Aesthetics ☐ Weight Loss ☐ Intimate Health

☐ Muscle Building ☐ Longevity ☐ Peptide Therapy

☐ Joint/Tissue Repair ☐ Anti-Aging ☐ Skin Health

☐ Sleep Improvement ☐ Cognitive Enhancement

Peptide History:

Have you used peptides before? Yes/No

If yes, which peptides did you use and why did you stop

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Medical History: (Check All that Apply)

( ) High blood pressure.

( ) Heart Disease

( ) Heart Attack or Stroke

( ) Irregular Cycles

( ) Diabetes Type 1 or 2

( ) Thyroid disease

( ) Liver Disease

( ) Kidney disease

( ) Lung Disease

( ) Blood clot and/or a pulmonary emboli.

( ) Arthritis

( ) Cancer (type?)_____

( ) PCOS

( ) Other:_____

( ) Pancreatitis

( ) Hysterectomy

( ) Menopause

( ) Autoimmune Condition(s):_____

( ) Asthma

( ) High Cholesterol

( ) Sleep Apnea

( ) Prostate Problems

( ) History of Stroke

( ) History of Seizures

( ) Hypothyroidism

( ) Depression

( ) Metal implants/pacemakers/heart monitor

Gynecological History:

Last PAP: _____ PAP Results: Normal Abnormal (circle one)

Last Menstrual Cycle:_____

HSV History: Yes No (circle one)

What, if any, birth control method are you currently using? _____

Are you currently pregnant, breastfeeding or trying to become pregnant?

_____

Previous or Past Surgeries and dates:_____

Urology History:

Last PSA: _____ PSA Results: Normal Abnormal (circle one)

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If abnormal, nature of diagnosis and
treatment:_____

Nocturnal Penile Tumescence test: _____Results: Normal Abnormal (circle one)

Previous or Past Surgeries and dates:_____

HSV History: Yes No (circle one)

Family Medical History: (Please list condition and who)

_____ _____ _____

_____ _____ _____

Current Medications: (including Vitamins and Supplements)

_____ _____ _____

_____ _____ _____

Allergies: (medication or injection related)

_____ _____ _____

_____ _____ _____

Social History:

( ) I smoke cigarettes, cannabis or cigars _____per day.
( ) I use caffeine _____a day.
( ) I drink alcoholic beverages _____per week.
( ) I am sexually active.

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PATIENT AUTHORIZATION FOR CONTACT & DISCLOSURE OF PROTECTED HEALTH INFORMATION

THIS FORM INSTRUCTS US WHO ELSE SHOULD GET YOUR MEDICAL INFORMATION. YOUR DOCTORS ARE ALWAYS INFORMED, SO DO NOT LIST THEM.

1. I authorize Bubolo Medical to disclose my protected health information to:

- **Family member(s)**

Name	**Phone Number**

- **Non- Family Members**

Name	**Phone Number**

- **Myself Only**

- **Other Healthcare Providers**

2. I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

    - Test results, reports, and general health updates
    - Nothing beyond general health questions & updates

3. I may be contacted with medical information by:

Email Address:
Phone Number:

Expiration or termination of authorization – This authorization will remain in effect until terminated by the patient's personal representative, or another individual or legal entity authorized to do so by a court order or law.

Right to revoke or terminate – As stated in our Notice of Privacy practices, you have the right to revoke or terminate authorization by submitting a written request to our Privacy Director.

By signing below, I acknowledge that I have received, reviewed, understood, and will comply with the policies and procedures explained in the Bubolo Medical Office Policies and Procedures for Patients form.

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Patient Signature _____ Date _____

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED

Patient Name: _____ Date of Birth: _____

This authorization is voluntary. Signing or refusing to sign will not affect my treatment, payment, enrollment, or eligibility for benefits in any way.

1. Information to Be Used or Disclosed

I authorize the use and disclosure of the following protected health information (PHI): before-and-after, during-treatment, and result photographs; video and/or audio recordings; my image, likeness, and voice; the fact that I received the following service(s) at Bubolo Medical: _____ (e.g., FUE hair restoration, PRP, aesthetic or wellness services); and any testimonial statements I choose to provide.

2. Who May Use/Disclose, and to Whom

Authorized to use/disclose: Bubolo Medical, LLC, its workforce, and its authorized marketing/advertising vendors.

May be disclosed to / used in (check all that apply): [ ] Bubolo Medical website [ ] social media (Instagram, Facebook, TikTok, etc.) [ ] paid digital/print advertising [ ] email/SMS marketing [ ] printed materials & in-office displays [ ] third-party marketing vendors engaged by Bubolo Medical [ ] general public.

3. Purpose

Marketing and promotion of Bubolo Medical's services, made at my request and with my consent.

4. Expiration

This authorization expires on [Date: _____] or upon [Event: _____]. If no date or event is entered, it expires **five (5) years** from the date signed or when I revoke it, whichever occurs first.

5. My Right to Revoke

I may revoke this authorization at any time by submitting a written request to the Bubolo Medical Privacy Officer at [Address / Email]. Revocation is prospective only: it stops future uses but does NOT apply to uses or disclosures already made in reliance on this authorization, and does NOT require Bubolo Medical to recall, remove, or retrieve materials already created, published, printed, distributed, or provided to third parties or the public before the revocation is received.

6. No Conditioning of Treatment

Bubolo Medical will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

7. Potential for Re-Disclosure

Information used or disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy law (HIPAA). Once images or information are made public — for example, on the internet or social media — they may be copied, shared, indexed, and reused by others, and it may be impossible to fully remove or retrieve them.

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8. Financial Remuneration

[ ] Bubolo Medical will NOT receive direct or indirect financial remuneration from a third party in exchange for this marketing use. [ ] Bubolo Medical WILL receive such remuneration; details: _____.

9. Compensation to Me (if any)

Consideration offered to me for this authorization, if any: _____. Except as stated, none is offered or due.

10. Acknowledgment

I signed this authorization voluntarily. I have read and understand it, I have had the chance to ask questions, and I am entitled to a copy.

Patient Signature: _____Date: _____

Patient Printed Name: _____

If signed by a personal representative —

Name: _____ Authority to act for patient: _____

Witness Signature: _____Witness Print: _____

PHOTO, VIDEO & LIKENESS RELEASE

For good and valuable consideration, the receipt and sufficiency of which I acknowledge, I, _____ ("I," "me," or "Model"), grant to **Bubolo Medical, LLC** ("Bubolo Medical"), and its affiliates, successors, assigns, and any persons acting with its authority and permission, the rights described below.

1. Grant of Rights

I grant Bubolo Medical the right to photograph, film, record, and otherwise capture my image, likeness, voice, and statements (the "Materials"), in any and all media now known or later developed.

2. Ownership

All Materials, and all rights in them including the copyright, are and shall remain the sole property of **Bubolo Medical, LLC**, free and clear of any claim by me or anyone acting on my behalf.

3. Permitted Uses, Scope & Compensation

Bubolo Medical may use, re-use, publish, re-publish, edit, alter, crop, combine with other content, distribute, and display the Materials for advertising, marketing, promotion, social media, website, editorial, training, trade, or any other lawful purpose.

Media: all media, including print, digital, broadcast, internet, and social platforms.

Territory: worldwide.

Duration: [perpetual] or [until _____].

Compensation: I understand I will not receive compensation. No compensation is or will be due to me for any use of the Materials.

4. Withdrawal of Consent (Prospective Only)

This release is effective when I sign it. I may withdraw it as to FUTURE uses by delivering written notice to Bubolo Medical at the contact below. Withdrawal takes effect only after Bubolo Medical actually receives my written notice and applies only going forward.

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Withdrawal does NOT require Bubolo Medical to recall, remove, alter, or stop using any Materials that were created, published, printed, distributed, or committed for use before Bubolo Medical received my notice, and does NOT require Bubolo Medical to retrieve Materials already provided to or in the possession of third parties or the public. Oral statements, negotiations, or inquiries do not constitute withdrawal.

Written notice to: Bubolo Medical 3889 Cobb Pkwy Acworth, Ga 30101

5. Release & Hold Harmless

I release, discharge, and agree to hold harmless Bubolo Medical, its representatives, assigns, and all persons acting under its authority from any liability arising from the capture, use, alteration, or distribution of the Materials, including any claim for invasion of privacy, right of publicity, defamation, or compensation.

6. Patient Notice (Medical Entities Only)

If I am a patient of Bubolo Medical, I understand this release governs my likeness only. It is separate from, and does not satisfy, any authorization required under HIPAA to use or disclose my protected health information for marketing. Such use also requires my signed HIPAA Marketing Authorization.

7. Acknowledgment

I warrant that I am of full legal age (or that a parent/guardian is signing for me) and have the right to contract in my own name. I have read this release, understand it, and sign it voluntarily. It binds me and my heirs, representatives, and assigns.

Print Name: _____**Date:** _____

Signature: _____**Phone:** _____

Address / Email: _____

Witness Signature: _____**Witness Print:** _____

If signer is a minor —
Parent/Guardian Name: _____ Signature: _____
Date: _____