ACNECLINIC NYC
ONLINE ACNE TREATMENT

Client: Kevin Morales (6177) Nov 14, 2025

1. Please note: fields with a red asterisk are mandatory.

Legal First Name: Kevin
Legal Last Name: Morales
Date of Birth: 11/25/1992 (age 32)
Minor's Guardian Full Name, If Applicable:
Gender: Male
Street Address of Residence: 21-48 35th St, 3c
Apt./Unit #: 3c
City of Residence: Astoria
State of Residence: NY
Zip Code: 11105
Mobile Phone: (347) 863-5542
Email: kevin7mrls@icloud.com

2. The client allows MedScape GFE to perform the good faith exam and for the good faith exam to be released to: AcneClinicNYC
Appointment made? Yes

3. Please state the date and time of the appointment:

11/14 10am

4. Check all treatments to have now or possibly would like in the future below: *Note: MedScape GFE does not determine the treatment route and/or dosages nor prescribes. AcneClinicNYC advises on treatment options within their clinic, scope of practice and protocols according to their medical director's guidelines.

☑ Laser Facial (CO2) ☑ Laser Facial (Erbuim)

5. Please answer the questions below relating to the selected treatment(s) above:

Have had selected treatment(s) before? No
Result of previous treatment(s)? Not applicable
Goal of requested treatment(s)? Select ALL that apply.
☑ Acne scarring
If needed, please explain further below:
Area(s) to be treated (this good faith is good for one year; therefore, approval can be for future treatments wanted): Cheek

6. Under any type of medical care? (i.e. PCP, OB/GYN, allergist, naturopath, mental health, specialist)

No

7. List ALL medications below including homeopathic supplements and vitamins. If none apply, please write in "none".

	Name of Medication:	Start Date:
1	None	

8. List ALL surgeries and hospitalizations below. This includes ALL implantation of objects placed in the body that one is not born with ie devices, stents, piercings. If none apply, please write in "none".

	Type of Surgery/Hospitalization:	Date and Year of Surgery/Hospitalization:
1	None	

9. List ALL allergies below and/or dietary restrictions. If none apply, please write in "none".

	Type of Allergy:	Reaction:
1	None	

10. Vitals & Measurements

Height (ft/in or cm)
5’9

Weight (lbs or kg)
205

Have you noticed any recent changes in your weight?
No

Do you have personal wellness or body goals you’d like us to know about?
No

If "other", please specify

11. Health History - Circulatory and Respiratory System (Please select all that apply):

☑ None of these

12. Health History - Nervous System (Please select all that apply):

☑ None of these

If "other", please specify

13. Health History - Digestive System (Please select all that apply):

☑ None of these

If "other", please specify

14. Health History - Skin (Please select all that apply):

☑ None of These

If "other", please specify

15. Health History - Mental Health & Emotional Well-Being

Do you have a history of depression, anxiety, or other mental health conditions?
No

If yes, are you currently receiving treatment (medication, counseling, or therapy)? N/A for none.
No

Have you ever been hospitalized for a mental health condition?
No

If yes, please specify when and which hospital. N/A for none.
No

If "other", please specify

16. Health History - Sexual Health & Hormones

Do you experience sexual dysfunction (low libido, erectile difficulties, vaginal dryness, or other concerns)?
No

If yes, please specify. N/A for none.
No

Have you noticed changes in your energy, mood, or sleep patterns that you think may be hormone-related?
No

Have you ever had a hormone evaluation (testosterone, estrogen, thyroid, cortisol, etc.)?
No

Would you like to have a hormonal evaluation via lab work?
No

If "other", please specify

17. Health History - Hair & Skin Health

Do you currently experience hair loss, thinning, or shedding?
No

Have you tried any treatments for hair loss in the past?
No

Would you like a consultation about hair loss?
No

Do you have a history of skin disorders (acne, eczema, psoriasis, etc.)?
No

If "other", please specify

18. Health History - Other (Please select all that apply):

☑ None of these

If "other", please specify

19. Please answer the lifestyle questions below:

Average stress level:
Moderate

Smoke, vape, or chew tobacco?
Quit

On average, how many days per week for alcohol consumption?
Quit

Recreational drugs?
Quit

On average, how many glasses of fluids (including water, juice, and decaffeinated tea) are consumed daily? (Glass = 8 ounces)
Around 4-8 glasses

Currently following any specific diet plan? If so, please specify which one(s): ☑ None of these

20. Approval and/or deferral to medical director's SOPs (description of treatment(s) that client is approved and/or deferred for). Please select all that apply treatments for approved and/or deferred to medical director's SOPs with AcneClinicNYC. MedScape GFE does NOT condone any off label administration or dosing of ANY treatments. We will approve, however, it is ONLY depending on if AcneClinicNYCs medical director allows for off label treatment(s). For any off label administration and dosage, AcneClinicNYC must follow policies and procedures as approved by your clinics medical director. If AcneClinicNYC's medical director does not allow for said off label treatment(s), the good faith exam note provided by MedScape GFE's and the high-level provider will be null and void.

Treatment(s) client is approved and/or denied to receive at AcneClinicNYC (select ALL that apply to visit):
☑ Cortisone Shots ☑ Dermal Filler ☑ Neurotoxin ☑ Sculptra ☑ Laser Facial (Nd:Yag 1064nm) ☑ Laser Facial (CO2) ☑ Laser Facial (Alexandrite)

Treatment(s) deferred to AcneClinicNYC medical director's SOPs with the reason(s) for deferral. If no explanation(s) is/are necessary, please write "not applicable":
NA

Clarification(s) needed from the client before approval. The client MUST resubmit with clarification(s) requested by the good faith exam high-level provider. If the client does not provide what the good faith exam high-level provider requests, the note is void, and therefore, the client is denied. If no explanation(s) is/are necessary, please write "not applicable":
NA

Term(s) of approved treatment(s) (select ALL that apply):
☑ 1 year (unless medical condition(s) change, medication(s) change and/or anything if anything is added to what is stated and approved in this GFE. If any of the aforementioned apply, the client must be re-seen at the time of discovery AND before their next appointment/treatment(s)

Provide treatment name(s) and explanation(s) for short-term approval(s) (under one year approval). If no explanation(s) is/are necessary, please write "not applicable":
NA

e-signature Nov 14, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

*Signed by Danielle Trenelli on Nov 14, 2025 at 11:59 AM from IP 71.127.239.****