ACNECLINIC NYC
ONLINE ACNE TREATMENT

Client: Ashley Bean (6137) Nov 13, 2025

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

Legal First Name: Ashley
Legal Last Name: Bean
Date of Birth: 4/3/1995 (age 30)
Minor's Guardian Full Name, If Applicable:
Gender: Female
Street Address of Residence: 1746 Troutman Street
Apt./Unit #:
City of Residence: Ridgewood
State of Residence: NY
Zip Code: 11385
Mobile Phone: (919) 349-0234
Email: info@ashbeanphoto.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:

Friday 11/14 @ 11:10am

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.

☑ RF Microneedling

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

Have had selected treatment(s) before? Yes
Result of previous treatment(s)? Excellent results
Goal of requested treatment(s)? Select ALL that apply.
☑ Acne scarring ☑ Improve skin texture
☑ Pigmentation/brown spots
☑ Reduce fine lines ☑ Rosacea/redness in skin
☑ Smoother, clearer skin
☑ Stimulate collagen production
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):
Face / neck

6. "Yes" was selected for previous treatment(s). Please list treatment(s) history below. If more space is needed please add more rows by hitting the "add rows" button.

	Treatment	Last Treatment
1	Lasers / Microneedling	June 2025

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

Yes

8. "Yes" for medical care was selected. Please list the provider's name(s) and their speciality.

	Name	Speciality
1	Alyssa Korenstein	PCP

9. For female assigned gender at birth:

Currently pregnant? ☑ No

Trying to become pregnant? ☑ No

Could possibly be pregnant? ☑ No

Currently breastfeeding? ☑ No

Going through IVF/Planning on IVF in the near future? ☑ No

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

	Name of Medication:	Start Date:
1	Adderall	2016

11. 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	

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

	Type of Allergy:	Reaction:
1	None	

13. Vitals & Measurements

Height (ft/in or cm)
4'11

Weight (lbs or kg)
99

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

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

☑ None of these

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

☑ None of these

If "other", please specify

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

☑ None of these

If "other", please specify

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

☑ Acne

If "other", please specify

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

Do you have a history of depression, anxiety, or other mental health conditions?
Yes

If yes, are you currently receiving treatment (medication, counseling, or therapy)? N/A for none.
Yes

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

If yes, please specify when and which hospital. N/A for none.
N/a

If "other", please specify

19. 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.
N/a

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

20. 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

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

☑ None of these

If "other", please specify

22. Please answer the lifestyle questions below:

Average stress level:
Moderate

Smoke, vape, or chew tobacco?
None

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

Recreational drugs?
None

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): ☑ Vegetarian

23. 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 13, 2025

Good Faith Exam completed by the following MedScape GFE Practitioner:

Danielle Trenelli, FNP-BC

*Signed by Danielle Trenelli on Nov 13, 2025 at 12:54 PM from IP 71.127.239.****