ACNECLINIC NYC
ONLINE ACNE TREATMENT

Client: Julia Mozilo (6160) Nov 13, 2025

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

Legal First Name: Julia
Legal Last Name: Mozilo
Date of Birth: 02/25/1999 (age 26)
Minor's Guardian Full Name, If Applicable:
Gender: Female
Street Address of Residence: 336 East 19th St
Apt./Unit #: 3F
City of Residence: New York
State of Residence: NY
Zip Code: 10003
Mobile Phone: (626) 710-3991
Email: julia.mozilo@gmail.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:

11/13/25 at 11:00AM

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 (Alexandrite)

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 ☑ Pigmentation/brown spots
☑ Smoother, clearer skin
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):
chin, cheeks, forehead

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	Laser	

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

No

8. For female assigned gender at birth:

Currently pregnant? ☑ No

Could possibly be pregnant? ☑ No

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

Trying to become pregnant? ☑ No

Currently breastfeeding? ☑ No

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

	Name of Medication:	Start Date:
1	none	

10. 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	

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

	Type of Allergy:	Reaction:
1	none	

12. Vitals & Measurements

Height (ft/in or cm)
5/6

Weight (lbs or kg)
140

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

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

☑ None of these

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

☑ None of these

If "other", please specify

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

☑ None of these

If "other", please specify

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

☑ Acne
hormonal

☑ Melasma
in the summer above my mouth

If "other", please specify

17. 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.
NA

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

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

If "other", please specify

18. 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.
NA

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?

If "other", please specify

19. 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.)?
Yes

If "other", please specify

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

☑ None of these

If "other", please specify

21. Please answer the lifestyle questions below:

Average stress level:
Low

Smoke, vape, or chew tobacco?
None

On average, how many days per week for alcohol consumption?
Occasionally (a few times a month)

Recreational drugs?
None

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

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

22. 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 01:10 PM from IP 71.127.239.****