

### PATIENT INFORMATION

Date \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name Middle Initial

SS # \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email address \_\_\_\_\_

Would you like to receive specials via email? Y N

Sex  M  F  X Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Single  Married  Divorced  Widowed

Minor  Domestic Partner  Separated

Responsible Party \_\_\_\_\_

Profession \_\_\_\_\_

Patient Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone (\_\_\_\_) \_\_\_\_\_

### MEDICAL HISTORY INFORMATION

Medications Please list any medications you are currently taking OR do you give us permission to access your pharmacy's medication list for you Y N

Allergies (List any known allergies, including medication, food, environmental) \_\_\_\_\_

Known Illnesses/Diseases/Major Surgeries/Pacemakers/Organ Transplants or Other Foreign Bodies \_\_\_\_\_

Pharmacy Contact Name, Address, Phone Number \_\_\_\_\_

### PHONE NUMBERS

**BEST contact #** (\_\_\_\_) \_\_\_\_\_ **Can we leave a message at this number?** Y N

**Can we TEXT to this number?** Y N

Additional # (\_\_\_\_) \_\_\_\_\_ **Can we leave a message at this number?** Y N

Emergency Contact Name \_\_\_\_\_

Emergency Contact Phone (\_\_\_\_) \_\_\_\_\_

### REFERRALS

The greatest compliment we receive from our patients is the referral of your friends and family. Whom may we thank for referring you? \_\_\_\_\_

Remember—cosmetic referrals can get you a \$25.00 gift certificate to use at an upcoming cosmetic appointment or for products!

**SEE REVERSE** 

## No-Show and Cancellation Policy

**Our offices require 24 hour notice if you are unable to make your appointment.** Courtesy reminder calls and/or texts are attempted 24-48 hours before your appointment. **If you do not comply with the 24 hour notice, we will bill you a minimum of a \$50 fee for the date of service missed. Longer services or surgeries may have additional fees.** Payment on this charge is required before making future appointments.

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient (or Guardian) Signature

## HIPAA Compliance

A Notice of Privacy Practices is available. Please ask for a copy so that you may review the policy and understand your rights and our compliance. Please sign below that you acknowledge our compliance.

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient (or Guardian) Signature

## Financial Payment Agreement

The financial payment policies of this office include:

- Whether you belong to an insurance plan or we are not a provider within your insurance network, you are responsible for all charges. Applicable co-payments will be collected at the time of your visit; deductibles and co-insurance payments will be billed to you. Sometimes your insurance company may remit a check payment directly to you for services rendered by us—but these monies are due to us and will be billed accordingly.
- For cosmetic procedures, all payments are expected at the time of service, unless other arrangements have been made prior to treatment. We do not send bills for cosmetic procedures, nor do we put balances “on account”. If you are purchasing a package treatment series, payment arrangements will be discussed with you and agreed upon prior to beginning treatment. You will also be required to sign consents for any cosmetic procedures.
- Certain medical procedures may require us to send tissue or specimens to a lab. The lab coordinates care with us but they will bill you separately for these charges. We do not control their charges or have any ability to work with them in regards to your payments.
- We accept payment in the form of cash, check, Care Credit, or credit card (Visa, Mastercard, Discover, and American Express). We do not hold checks. A \$25.00 NSF fee will be charged for returned checks and your account will be turned over to the District Attorney and/or our collection agency in the event of an NSF check as well.
- We have an agreement with Transworld GreenFlag Collections Agency regarding accounts that do not pay in a timely manner. We will send statements before sending your account to collections. In the event your account is sent to Transworld, a fee of \$15.00 *minimum* will be added to your account and due by you along with the fees which you owe for your services.

By signing below, I acknowledge that I understand the financial terms described above and agree to adhere to these.

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient (or Guardian) Signature