

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 Phone (____) _____

Is there another person you would like to authorize for your records, bills, etc. _____

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 

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. Deductibles and co-insurance are additional amounts due – they are determined by your specific insurance contract. If you do not know how they work or what you are required to pay for medical services in addition to co-pays, please consult your insurance to discuss. Sometimes your insurance company may remit a check payment directly to you for services rendered by us—this depends on your insurance plan—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 regard to your payments.
- Our good faith estimates for future self pay medical services are given verbally and noted in your medical visit note. They are good for a maximum of 6 months and then will need to be redone. If you would like a good faith estimate in writing, please let us know.
- Any fees for missed appointments or no shows will be required to be paid prior to new visits. We never intend to waste your time, and we ask that you do not waste ours or other patients’.
- 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 – if you provide an email address we will also send you an email as a final reminder. 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. Our goal is never to send anyone to collections. Please help us to do this by contacting our office if you are unable to pay your bill for any reason so we can discuss options with you.

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

Date ____/____/____

Patient (or Guardian) Signature