

**Aesthetic Solutions**  
5821 Farrington Rd. Suite 101 Chapel Hill, NC 27517  
(919) 403-6200/ FAX (919) 403-6242  
www.aesthetic-solutions.com

**I. PERSONAL INFORMATION**

Chart # \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Gender:** Male  Female   
**Address:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
**City, State, ZIP:** \_\_\_\_\_ **Single**  **Married**  **Other**   
For the National Skin Cancer Registry, we must collect your **Race:** \_\_\_\_\_ **SSN** \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Home Phone Number: (\_\_\_\_) \_\_\_\_\_ May we leave a message at your home? No Yes  
Work Phone Number: (\_\_\_\_) \_\_\_\_\_ May we call you at work? No Yes  
Cell Phone Number: (\_\_\_\_) \_\_\_\_\_ May we call you on your cell? No Yes  
Email Address: \_\_\_\_\_ May we contact you via email? No Yes\*

For secure patient communications via email, we use Barracuda. You will be prompted to create an account upon receipt.

**How did you hear about Aesthetic Solutions?**

- |   |  |
|---|--|
| <input type="checkbox"/> Referring Physician: _____ | <input type="checkbox"/> Community Event _____ |
| <input type="checkbox"/> Internet                   | <input type="checkbox"/> Facebook              |
| <input type="checkbox"/> Patient / Friend           | <input type="checkbox"/> LinkedIn              |
| <input type="checkbox"/> Insurance Company          | <input type="checkbox"/> Other                 |

Check if you do **NOT** wish to receive newsletters or promotions \_\_\_\_\_ (We will not share or sell demographic information with third parties).

If patient is under 18 years old, **PARENTS:** please complete *your* info below.

Parent's Name, SS#, Date of Birth: \_\_\_\_\_

**Please note that Parents or Authorized persons must accompany minors to their appointments.**

**If you authorize Aesthetic Solutions to disclose relevant personal health information to a Designated Party, complete below** (Please see separate Notice of Privacy Practices).

Designated Person Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Home/Cell Phone Number: \_\_\_\_\_  
Work Phone Number: \_\_\_\_\_

**II. INSURANCE INFORMATION** – Please provide our office with copies of your insurance cards. We accept BCBS of NC, CIGNA, Medicare, United Healthcare, Coventry (Wellpath / Duke Select/Basic). It is the patient's responsibility to know his/her insurance benefits and to secure a referral, if necessary, from the Primary Care Physician. If you choose to go out of network, you are fully responsible for the fees.

**Primary Ins:** \_\_\_\_\_ Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Secondary Ins:** \_\_\_\_\_ Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_

**III. FINANCIAL RESPONSIBILITY STATEMENT** Our Fee for Appointments – Cosmetic Consultations \$125.00

I authorize the release of any personal health information for collection purposes. I am financially responsible for any elective, non-covered services, deductibles, and co-payment amounts due to Aesthetic Solutions.

How will the bill be paid today? Please circle: Cash, Checks, Visa, MasterCard, AMEX, and Discover

**RESPONSIBLE PARTY/ ADDRESS:** \_\_\_\_\_

I read the Financial Responsibility statement above.

**Patient / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FORM MUST BE UPDATED EVERY 2 YEARS**

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Patient Name: \_\_\_\_\_ Chart # \_\_\_\_\_

**This is part of your CONFIDENTIAL Medical Record.**

Reason for Consultation: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Medications / Dosages Taken Regularly: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you taking Aspirin or any medication containing Aspirin? No Yes If yes, which? \_\_\_\_\_

Are you taking any Vitamins / Herbs? No Yes If yes, which? \_\_\_\_\_

Have you had any reaction to injections of a local anesthetic? No Yes If yes, which? \_\_\_\_\_

Are you allergic to band aids, tape or adhesive? No Yes If yes, which? \_\_\_\_\_

Date of last physical: \_\_\_\_\_ Physician: \_\_\_\_\_

Previous Surgeries, dates and attending Physicians:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Female Patients Only: Are you taking oral contraceptives? No Yes If yes, which? \_\_\_\_\_

Are you pregnant or trying to become pregnant? No Yes

**GENERAL HEALTH**

	YES	NO	
Cancer, specify	<input type="checkbox"/>	<input type="checkbox"/>	Have you had an Electrocardiogram (EKG) in the past year? _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Normal Results? _____
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Have you been under a physician's care in the past or currently for any
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	medical condition? If so, what condition and who is/was the physician?
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you get nauseated easily?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have HIV or HIV risk factors?	<input type="checkbox"/>	<input type="checkbox"/>	

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FORM MUST BE UPDATED EVERY 2 YEARS**

**Financial Policy**

Patient Name: \_\_\_\_\_ Chart # \_\_\_\_\_

**Our Fee for Appointments – Cosmetic Consultations \$125.00**

Thank you for choosing us as your health care provider. We are committed to assuring an exceptional experience with our practice and hope this information will be helpful to you. Our fee for cosmetic consultations is \$125.00. A cosmetic consult is an evaluation by our healthcare providers about cosmetic treatment options you may wish to address. No treatment is included in this fee. It may be possible to offer treatment during your visit, and if this is possible, the consult fee will be applied to your treatment fee. Our fee for all other appointment types is \$125.00.

**You, the patient, are responsible for payment for our services. We will bill your insurance company when appropriate, but responsibility for payment remains with you. Cosmetic, medically-unnecessary services are not covered by Medicare or private insurance.**

**Insurance:**

- We accept BCBS of NC, CIGNA, Medicare, United Healthcare, Coventry (Wellpath / Duke Select/Basic). This means we have agreed to bill covered services and accept a contracted fee.
- Your insurance policy is a contract between you and your insurance provider. If your insurance claim is denied, you are responsible for payment.
- **All co-pays and deductibles are due the day rendered services.**
- It is your responsibility to determine if a referral is needed for our services.
- It is your responsibility to provide us with your insurance information, and to notify us if your coverage changes. Please bring a copy of your insurance card with you to avoid being charged at completion of your visit.
- Payments received from your insurance carrier will be immediately posted to your account. You will be billed for any balance due.
- If a payment received from your insurance company results in a credit balance to your account, we will hold the credit balance and apply it to your future charges. During the month of January in each calendar year, we will refund by check all credit balances on patient accounts unless otherwise instructed. Checks will be sent to your address on file.

**Surgery Scheduling for Liposuction and Laser Resurfacing**

We charge a nonrefundable scheduling fee of \$500.00 to reserve our surgical suite. This fee is credited to your surgery. If you are unable to keep your surgery appointment, please cancel at least 14 days prior to your surgery. If you cancel less than 14 days from the date of surgery, you will forfeit your surgical booking fee, and will need to pay another \$500 scheduling fee to reschedule your surgery. Surgeries must be paid in full at the pre-operative appointment. Quotes are valid 180 days.

**Missed Appointments:**

If you have provided a valid telephone number and/or email address, our automatic appointment confirmation system will contact you 2-7 days prior to your appointment. Unless cancelled via a phone call or email to our office 48 hours in advance, we reserve the right to charge for missed appointments at the prevailing rate. Please help us serve you better by keeping scheduled appointments. Please note that we do not accept cancellations via phone texts.

**Finance Charges / Returned Checks**

We charge interest of 1.5% monthly (18% APR) on unpaid balances, beginning 30 days from the date you are invoiced. We will charge your account \$30.00 for each returned check. If two (2) or more of your checks are returned by your bank unpaid, only cash or credit cards will be accepted for future visits.

**Skin Products: Non-Returnable / Non-Refundable**

We sell skin care products in our office. You are not required to purchase these products. You may find these or comparable products elsewhere. Please note all prescription products require an office visit and cannot be mailed.

**I have read the Financial Policy. I understand and agree to this Financial Policy.**

Signature: \_\_\_\_\_ (SEAL) Date: \_\_\_\_\_