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?

- ❑ Referring Physician: ____________
- ❑ Internet
- ❑ Patient / Friend
- ❑ Insurance Company
- ❑ Community Event ________________________
- ❑ Facebook
- ❑ LinkedIn
- ❑ 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 AETNA, 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	☐	☐
Diabetes	☐	☐
Eye Problems	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Anemia	☐	☐
Ulcers	☐	☐
Lung Problems	☐	☐
Psychiatric Disorders	☐	☐
Rheumatic Fever	☐	☐
Do you get nauseated easily?	☐	☐
Do you smoke?	☐	☐
Do you have Hepatitis	☐	☐
Do you have HIV or HIV risk factors?	☐	☐

Have you had an Electrocardiogram (EKG) in the past year?_________
Normal Results?__________________________________

Have you been under a physician's care in the past or currently for any medical condition? If so, what condition and who is/was the physician?

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____

Signature:____ **Date:** ____________

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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 the healthcare provider and discussion of treatment options you may wish to consider. No treatment is included in this fee. It may sometimes be possible to offer treatment during your visit. If this is possible and you choose to have treatment at this visit, the consult fee will be applied to your treatment. 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 AETNA, BCBS of NC, CIGNA, Medicare, United Healthcare, Coventry (Wellpath / Duke Select/Basic). This means we have agreed to accept a contracted fee for each service type, and we will bill your insurance company.
- 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 you insurance company results in a credit balance to your account in excess of $25.00, we will mail a refund check to your address on record. Credit balances less than $25 will be held and applied to your next bill, unless you request a refund check be mailed to your address on record.

Treatment Package Pricing

Some services provided by our aestheticians require multiple treatments for maximum benefit, and are offered as packages at reduced cost. All package purchases are non-refundable, unless there is a medical reason you cannot complete treatment. If you do not complete treatment for any non-medical reason, we will charge the regular, non-discounted price for each completed treatment, and credit your account with the unused balance. You may use this credit balance for any aesthetic, non-insurance compensated services.

Skin Care Products

We sell medical-grade skin care products with clinically proven benefits. We encourage use of medical-grade products, but you are not required to purchase these products from us, and may find the same or comparable products elsewhere. Skin care products are non-returnable / non-refundable once opened. We offer 20% off skin care products when three or more products are purchased at the same time. If you later return an unopened product, we will adjust the prior sale to regular prices for each product, and refund the credit balance, if any. Please note all prescription products require an office visit to obtain a prescription. Prescription products cannot be shipped.

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 it is performed on the scheduled date, or re-scheduled with at least 14 day's notice. If you cancel less than 14 days from the date of surgery, you forfeit the fee and it will not be applied to any future surgery. If you wish to reschedule, you will need to pay another $500 scheduling fee. Surgeries must be paid in full at the pre-operative appointment. Quotes are valid 180 days.

Missed Appointments:

We reserve the right to charge for missed appointments. Patients who miss 2 appointments without cancelling at least 48 hrs in advance will be unable to schedule another appointment without paying $125 in advance. 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. Please help us serve you better by keeping scheduled appointments. Please note we cannot 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.

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

Signature:____(SEAL) **Date:** ____________