Aesthetic Solutions
DERMATOLOGY • LASER • RESEARCH

5821 Farrington Rd. Suite 101 Chapel Hill, NC 27517
Phone (919) 403-6200/ Fax (919) 403-6242
www.aesthetic-solutions.com

Personal Information

Chart #:___________

Patient Name: ____ Sex: Male ☐ Female ☐
Address:____Date of Birth:____________Age:_______
City, State, Zip:____Single ☐ Married ☐ Other ☐

For the National Skin Cancer Registry, we must collect your Race: ___________________________________

Occupation:_______________________________________Employer: ______________________________

Home Phone Number:(_______)________________________ May we call you at home? ☐ Yes ☐No

Work Phone Number:(_______)________________________ May we call you at work? ☐ Yes ☐No

Cell Phone Number:(_______)_________________________ May we call you on your cell? ☐ Yes ☐No

Email Address:_____________________________________ May we contact you via email? ☐ Yes* ☐No

**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:_____________
- ☐ Patient / Friend
- ☐ Google
- ☐ Social Media
- ☐ Print
- ☐ Radio
- ☐ TV
- ☐ Other:______

☐ Check if you do **NOT** wish to receive our educational newsletters and specials. We do not share any information with third parties.

Emergency Contact

Name:____

Address:____

City, State, Zip Code:____

Home phone: ____________________ Cell phone:_______________________

If you authorize Aesthetic Solutions to disclose relevant personal health information to a Designated Party, complete below.

☐ If s**ame as emergency contact**

Designated Person Name:________________________________Relationship to patient: _______________________
Address:____Home/Cell Phone Number:_____________________
____Work Phone Number:________________________

If someone other than patient is responsible for payment:

Responsible Person Name:__________________________

Address:____

City, State, Zip Code:____

Home phone: ____________________ Cell phone:_______________________

FINANCIAL RESPONSIBILITY STATEMENT

I have received a copy of the Financial Policy. I understand and agree I am financially responsible for all amounts due Aesthetic Solutions. I authorize the release of my personal health information as necessary to collect payment. We accept cash, check, major credit cards and Care Credit for charges over $500. Care Credit terms and conditions do apply.

Patient or 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 Visit: ____

Drug Allergies and the reaction you have from them:______________________________________

____

Medications:____

____

____

Are you taking Aspirin or any medication containing Aspirin? ☐ No ☐ **Yes** If yes, which?_______________________

Are you Pregnant or Breast Feeding? ☐ 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?___________________________

Previous Surgeries:

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?	☐	☐
Do you have a pacemaker/defibrillator?	☐	☐
Do you have metal implants?	☐	☐
Are you allergic to bee stings?	☐	☐
Any neuromuscular disease?	☐	☐

Have you had injectable fillers in the past? Yes ☐ No ☐
If yes please list: ____

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?

____

____

____

____

____

____

____

Date of your last Dermatology Full Body Exam: ________________

Signature:____**Date:** ______________

Date last reviewed/updated:

Signature	*Date*	*Signature*	*Date*
______________________	__________	______________________	__________
______________________	__________	______________________	__________

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Financial Policy

Patient Name:____Chart # ____________________

Thank you for choosing us! We are committed to assuring an exceptional experience with our practice and hope this information will be helpful to you.

Consultation with a Physician
We charge $125 for all office visits with a physician. This covers evaluation, diagnosis and recommendations. Additional services are billed separately, and all costs will be explained prior to treatment. The office visit charge will be waived when Botox, Dysport, Xeomin, any dermal filler (except Sculptra), VBeam laser or Alex laser **treatment is performed during the same visit.**

Consultation with an Aesthetician
We do not charge an office visit for a consultation with our aestheticians. The aesthetician will confer with our physicians, and a physician may stop by to confirm the aesthetician's recommendation. This is not a cosmetic consult and will not include evaluation of issues unrelated to the purpose of your appointment.

Treatment Package Pricing
Some services require multiple treatments for maximum benefit and are offered as packages at reduced cost. Payment for that package is required prior to or at the time of first treatment. If you do not complete all treatments, we will re-calculate the cost of completed treatment at the single treatment rate, and refund or credit your account the unused portion.

Skin Care Products
We recommend medical-grade skin care products with clinically proven benefits. We sell these products in our office, but you may find the same or comparable products elsewhere (please be sure they are unexpired, genuine products that have been stored properly). Opened products may not be returne. Refunds will be given for return of unopened products within 30 days of purchase. Please note all prescription products require an office visit to obtain a prescription. Prescription products cannot be shipped.
Prescription products may not be returned once they leave the practice.

Missed Appointments / Late Cancellations / Procedure Deposits
We charge $50 for missed appointments and appointments cancelled with less than 24 hours of notice. Some appointments require a deposit, and may have longer notice requirements. For those appointments, you forfeit your deposit if you late cancel or no show the appointment. The deposit and notice period will be included in the quote offered for your treatment.

We text and email 7 days before your appointment. We text and email 48 hrs before your appointment. We telephone if you do not respond to these reminders. We reserve the right to cancel your appointment if you do not respond to these reminders.

Late Arriving Patients
Patients arriving more than 15 minutes late will be rescheduled.

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 and understand this Financial Policy, and agree I am personally responsible for payment. I agree to the release of my personal health information as necessary to collect payment. I understand Aesthetic Solutions does not accept any commercial or government provided insurance, and does not communicate with, or coordinate care with any insurance company. I understand I will be offered an itemized receipt for services. If I have any questions about this Financial Policy, I understand I may contact the Practice Manager at 919-578-8260.

Signature:____**Date:**______________

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Notice of Privacy Practices

We are committed to protecting the privacy of the medical information and other personal information we keep regarding our patients. We call this information Protected Health Information or "PHI" throughout this notice. We are required by law to maintain the privacy of your Protected Health Information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice is effective as of September 1st 2014 and will remain in place until we replace it.

We reserve the right to change this notice and our privacy practices at any time, provided such changes are permitted by applicable law. We also reserve the right to make the changes in our privacy practices and the new notice effective for all PHI that we already have about you as well as for PHI that we may receive in the future. Before we make a material change in our privacy practices, we will update this notice and post on our website.

You may request a copy of this notice by calling our office at (919) 403-6200. You may also obtain a copy from our Web site at www.aesthetic-solutions.com. For more information or questions about our privacy practices, please contact our Privacy Officer Joel Panara in person at the practice, by email at jpanara@aesthetic-solutions.com, or by telephone at 919-403-6200.

How We Use and Disclose Your Protected Health Information

We may use and disclose your PHI as permitted by federal and state privacy laws and regulations, including the federal health care privacy regulations known as "HIPAA." If an applicable state privacy law is more protective of your health information or is more stringent than HIPAA, we will follow the state law. For example, some state laws have stricter requirements about disclosing information about certain conditions or treatment for certain conditions such as HIV, AIDS, mental health, substance abuse/chemical dependency, genetic testing or reproductive rights. If you cease to be a patient, we will no longer disclose your PHI, except as permitted or required by law.

We may use and disclose your PHI for the following purposes:

Payment. Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you.

Health Care Operations. We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice**.** These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party 'business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services provided by our practice that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive such information. In this case, the disclosure will be consistent with the requirements of applicable federal and state laws.

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Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization.
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. The use and disclosure of your protected health information for marketing and sale purposes requires your written authorization which can be revoked after receiving written authorization to do so. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object
We may use and disclose your protected heath information in the following instances. You have the opportunity to agree or restrict the use or disclosure of all or part of you protected health information though we are not required to agree to such restrictions. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Disclosures to Health Plans: You have the right to request, via written authorization, your protected health information, regarding care you have paid for out-of-pocket (i.e. cosmetic treatments or procedures), to not be disclosed to health plans, unless for treatment purposes or in the rare event the disclosure is required by law.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other persons you identify, your personal health information that directly relates to that person's involvement in your health care. If you are unable to agree of object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person who is responsible for your health. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Breach Notification: We will investigate any discovered unauthorized use or disclosure of your medical information to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you of our intentions to mitigate the damage, if any, caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

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Patient Rights With Respect to PHI

Right to Access and Inspect Your PHI. You may ask to see or get a copy of certain PHI that we maintain about you. Your request must be in writing. You may visit our office to look at the PHI, or you may ask us to mail it to you, and in certain circumstances, this may include an electronic copy. We may charge a reasonable fee to cover the cost of copying the information. We will contact you to review the fee and obtain your agreement to pay the charges. If you wish to access your PHI, please contact our office. If you wish to amend your PHI, please call our Privacy Officer at (919) 403-6200 to submit the request.

Right to Amend Your PHI**.** You may ask us to correct, amend or delete your PHI. Your request must be in writing. We are not required to agree to make the change. For example, we will not generally change our information if we did not create the PHI or if we believe that the PHI is correct. If we deny your request, we will provide you a written explanation. You have the right to file a statement explaining why you disagree with our decision and providing what you believe is the correct, relevant and fair information. We will file the statement with your PHI and we will provide it to anyone who receives any future disclosures of your PHI. If we accept your amendment request, we will make reasonable efforts to inform others, including people you name, of the amendment and include the changes in any future disclosures of your PHI.

Right to Request an Accounting of Disclosures. You may ask to receive a list of certain disclosures of your PHI that we or our business associates made for purposes other than treatment, payment or health care operations. You are entitled to this accounting of disclosures for the six years prior to the date of your request. The list we provide will contain the date we made a disclosure, the name of the person or entity that received your PHI, a description of the PHI that we disclosed, the reason for the disclosure, and certain other information. We will not charge a fee for providing the list unless you make more than one request in a 12-month period, in which case we may charge a reasonable fee for preparing the list.

Right to Request Restrictions. You may ask us to not use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Our healthcare providers are not required to agree to a restriction that you may request. If your healthcare provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI information will not be restricted. You then have the right to use another healthcare provider.

Right to Confidential Communications. If you believe that a disclosure of your PHI could endanger you, you may ask us to communicate with you confidentially at a different location. For example, you may ask us to contact you at your work address or other place instead of your home address. Once we have received your confidential communications request, we will only communicate with you as directed on the confidential communications form, and we will also terminate any prior authorizations that you have filed with us.

Right to Obtain a Copy of this Privacy Notice. You may request a copy of this notice at any time by calling our office, or you may view or download this notice from our Web site. Even if you agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Right to File a Privacy Complaint. You may file a complaint with our Privacy Officer Joel Panara, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against your filing a complaint. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to your PHI.
You may refuse to consent to the use or disclosure of your personal health information. Under this law, we have the right to refuse treatment should you choose to not disclose your personal health information.

Patient Name:____ Chart #:____________________

Patient Signature:_____________________________________ Date :_____________________