

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?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Referring Physician: _____ | <input type="checkbox"/> Print |
| <input type="checkbox"/> Patient / Friend | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Google | <input type="checkbox"/> TV |
| <input type="checkbox"/> Social Media | <input type="checkbox"/> 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 same 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

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	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
Do you have a pacemaker/defibrillator?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have metal implants?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to bee stings?	<input type="checkbox"/>	<input type="checkbox"/>
Any neuromuscular disease?	<input type="checkbox"/>	<input type="checkbox"/>

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
_____	_____	_____	_____
_____	_____	_____	_____

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 returned. 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: _____

Privacy Policy

Effective date: October 1, 2020

This Privacy Policy (the "Policy") explains how Aesthetic Solutions ("us," "our," or "we") collects, uses, discloses, and protects information that we collect from you when you visit our location and obtain services from us (the "Services").

Information We Collect About You

When you use or access the Services, we may collect personal information, such as the following:

- Contact information, such as name, email address, or phone number.
- Information you submit when you contact us or visit our location.
- Information pertaining to the Services we provide you, including information necessary to facilitate and pay for the services you receive.
- Information pertaining to the Services you have expressed an interest in.

How We Use Your Information

We may use personal information that we collect about you for purposes that include the following:

- Providing the Services to you.
- To communicate with you and respond to requests.
- Understanding how you and others use our Services and to determine what features and services may interest you and others.
- Operating, evaluating, and improving our organization.
- For analytics, marketing, or advertising purposes.
- Storing information about your preferences and recognizing you when you obtain Services.
- Protecting the legal rights, property, safety, and security of us and you, including to comply with applicable law and industry standards and to enforce our policies, terms of use, or rights arising from contracts.
- For such purposes as you may authorize at the time you submit the information.

Disclosure of Your Information

We may disclose personal information we collect about you:

- To communicate with you.
- To our affiliates, business partners, contractors, service providers, and other third parties we use to support our organization, including those we contract with to provide analytics, marketing, or advertising services.
- To comply with any court order, law, or legal process, including to respond to any government or regulatory request.
- To enforce our policies, terms of use, or rights.
- To investigate or prevent unlawful activities and to protect the rights, property, or safety of us, our clients, or others.
- To a buyer or other successor.
- For such purposes as you may authorize at the time you submit the information.

Changes to this Policy

We may update this Policy to reflect changes in our privacy practices at any time without prior notice to you. When we do so, we will update the Effective Date of the Policy, above.

Contacting Us

If you have any questions or comments about this Policy or our privacy practices, please contact our Practice Manager at 919-403-6200, or 5821 Farrington Road, Chapel Hill, NC 27517.