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 **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

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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 $150 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 an injectable treatments are performed during the same visit.

Consultation with a PA We charge $100 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.

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 an 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 a 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 skincare 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 Our office requires 24 hours notice to cancel or reschedule an appointment. For New Patient appointments we require a deposit in the amount of the provider's consultation fee to hold the appointment time. The deposit is fully refundable if the appointment is cancelled with 24 hours notice. For appointments cancelled with less than 24 hours, or no-showed, the deposit is collected as a late cancellation fee. For existing patient appointments, 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 919-403-6200.

Signature:____**Date:**________________

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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.