NEW PATIENT INFORMATION

Carol Parker ▪ Alissa Saenz

Patient Name:________________________________ Date: ________________________________

Date of Birth:________________________________ Age: __________ Male ❑ Female ❑

Address:________________________________ City/State:________________________________

Home Phone: ( )________________________ Zip Code:________________________________

Cell Phone: ( )________________________ Employer: ________________________________

HOW DID YOU HEAR ABOUT DEVENIR AESTHETICS? Please be specific.

❑ Doctor:____________________ ❑ Friend/Family: ________________ ❑ Radio: ____________________

❑ Internet / Website:______________ ❑ Ad: ________________________ ❑ Other:____________________

Would you like to learn more about our no-interest finance options through Care Credit? ❑ Yes ❑ No
Would you like to receive special offers and notification of events from Devenir Aesthetics via-email? ❑ Yes ❑ No

Email: ________________________________

INSURANCE INFORMATION

Name of Insurance Carrier: ____

Name of Policy Holder: ____

SS#: ________________________ Date of Birth: __________________ Male / Female

Address (if different from above): ________________________________ City: ____________ State: ______

Phone Number: ( )______________________ Relationship to Patient: ________________________

SKIN CARE QUESTIONNAIRE

In order to better establish your skin type please tell us: Race/Ethnicity: ________________________

How much time do you spend in the sun? ❑ Always ❑ Sometimes ❑ Never Do you wear sunscreen? ❑ Yes ❑ No
If so, what brand & SPF? ______________________ Do you ever go to the tanning booth? ❑ Yes ❑ No

Please describe your skin: ____

Your skin type: ❑ Always burns, never tans ❑ Sometimes burns, sometimes tans ❑ Always tans, rarely burns

Do you have any skin or drug allergies? ____
If so, please explain your reaction(s): ____

Are you currently taking any prescription medications, or non prescription medication, vitamins or herbal supplements?
❑ Yes ❑ No Please specify: ____

Women: when was your last menstrual cycle? ____

Are you currently pregnant? ❑ Yes ❑ No If yes, due date? __________ Are you currently breastfeeding? ❑ Yes ❑ No

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Have you been diagnosed with any of the following?

❑ Melanoma ❑ Eczema ❑ Herpes Simplex (fever blisters)

❑ Hepatitis ❑ Thyroid Disease ❑ Diabetes

❑ Liver disease ❑ High Blood Pressure ❑ Skin cancer or precancerous

❑ Atypical or dysplastic moles ❑ Allergies or Hay Fever ❑ Other ____________________

❑ HIV ❑ Rosacea

Has anyone in your family ever been diagnosed with: ❑ Melanoma ❑ Skin Cancer ❑ Allergies ❑ Eczema

Are you currently being treated by a physician for any reason? ❑ Yes ❑ No
If yes, please specify: ____

Have you ever used or are you currently using Accutane? ❑ Yes ❑ No

Have you ever used or are you currently using RetinA® or any other prescription topicals? ❑ Yes ❑ No

Have you ever been treated for a hormonal condition? ❑ Yes ❑ No
If yes, please specify condition? ____

What products do you currently use on your skin? ____

Have you recently (in the area you want treated):
❑ Waxed ❑ Electrolysis ❑ Chemical Peel ❑ Laser or Pulsed Light ❑ Sunburned

What method of treatment, if any, are you currently using in the area?
❑ Waxing ❑ Tweezing ❑ Shaving ❑ Bleaching ❑ Depilatories ❑ Other: ____________________

Have you ever had any plastic surgeries? ❑ Yes ❑ No
If yes, please list types and dates: ____

Which treatments are you inquiring?

❑ Microdermabrasion ❑ Botox ❑ Extractions

❑ Chemical Peel ❑ Laser Hair Removal ❑ Skin Care Treatment

❑ Skin Rejuvenation ❑ Thermage ❑ Skincare / Product Consult

❑ Cosmetic Filler ❑ Active / Deep FX ❑ Vein Treatment

What are your expectations of this procedure? ____

By signing this form, I am stating the above information is complete and accurate to the best of my knowledge.

______________________________ ______________________________
Signature of Patient (or guardian) **Date**

DEVENIR AESTHETICS
FINANCIAL POLICY

THANK YOU FOR CHOOSING US AS YOUR HEALTHCARE PROVIDER
Our doctors and staff members are dedicated to serving your medical needs with the best professional advice, care and treatment obtainable. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment. We are glad that you are here and we want to do our very best for you. We sincerely hope that your visit will be a pleasant and rewarding experience. If you have any financial questions about your visit, please contact our Billing Department as soon as possible, as we may have deadlines to resolve any discrepancies. If you are dissatisfied in any way, or simply have feedback-positive or negative- it's important for us to know so that we can improve upon our services. Please feel free to call, write or email our Office Manager, Wendy Juarez (info@freshfaceaustin.com).

REVIEW OF NOTICE OF PRIVACY PRACTICES
Our office respects the HIPPA Regulations. We have a copy of the HIPPA Regulations available to you, if you choose to request it.

CONSULTATION FEE & CANCELLATION POLICY
All consultations are $50 and are redeemable with your next scheduled service with the same provider. It is the patient's responsibility to call the office to cancel 24 hours before their scheduled appointment. **Devenir Aesthetics reserves the right to charge the patient a $50.00 fee if the patient does not cancel the appointment 24 hours prior to his/her appointment time. Additionally, Devenir Aesthetics reserves the right to reschedule appointments to which the patient is more than 15 minutes late.**

PROOF OF IDENTITY
We are now required to have proof of your identity on file. We require a photo ID such as a Driver's License, work ID badge, etc. This will be copied into your private medical records only as a means to prove who we are treating. We understand that some people are reluctant to having their ID scanned. If this is the case, we may have to ask to view your photo ID at each visit.

PRIVATE PAY PATIENTS
Full payment is due at the time of service. We accept cash, checks, MasterCard, Visa, Discover, Amex, and CareCredit.

INSURANCE PLANS THAT WE ARE CONTRACTED WITH
In order for us to file your insurance we must have a copy of your current insurance card. If you do not have your insurance card, full payment may be due at the time of service. If you have enough information for us to verify your coverage, you may only need to pay your co-pay. You are responsible for all co-pays, cost-shares and deductibles the day of the visit.

** If your visit is strictly cosmetic, your insurance will not be billed and you will be responsible to make full payment at the time of service.

** If you have an insurance plan that we are not contracted with, full payment is due. We will gladly give you a claim form at the end of your appointment so that you may file the claim with your insurance company for reimbursement. In some instances, we may file your claim as a courtesy; however, full payment is still due at the time of service.

** Filing insurance claims is a service we provide free of charge but in no way relieves you from the responsibility of your bill. It is your responsibility to let us know of any insurance changes in a timely manner.

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PLEASE NOTE
We file claims to many different insurance companies, and it is virtually impossible for us to know all the many specific details of your policy. Please be aware that some, and perhaps all, of the services provided may be considered by your insurance company to be non-covered services and/or might be subject to a deductible in addition to your co-pay. You have the right to refuse any services rendered to you if you think they are non-covered services or not payable by your insurance company.
We will not become involved in disputes between you and your insurance company regarding non-covered charges, diagnoses, co-pays, cost-shares or deductibles. Please refrain from asking our office to change a diagnosis or procedure code in order for the visit to be covered by your insurance company.

MANAGED CARE PLANS OR HEALTH SELECT
It is your responsibility to obtain any and all necessary referrals to our office including referrals for follow up visits. We will strive to keep you informed on how many visits you have left on a referral and/or the expiration date. Ultimately, it is your responsibility to know this information and to make the necessary arrangements through your PCP.

MEDICAL RECORDS
If at any time, you should need copies of your complete medical records, there is a $25.00 processing fee. We require a written release to be signed and dated due to the HIPPA laws. There may be a high volume of requests ahead of yours, requiring anywhere from ten to fifteen days to complete your request so please try to plan ahead. If one of your other physicians needs only current notes, pathology or lab reports, their office can request these specific items be faxed to them directly free of charge.

RETURNED CHECKS
Checks returned for non-sufficient funds will be charged a fee of $25.00. We do not re-deposit an NSF check a second time. Balances must be handled by cash, credit card or money order.

PAST DUE ACCOUNTS
All outstanding accounts with NO PAYMENT ACTIVITY for 120 days are turned over to an outside collection agency and will be assessed an additional charge of $25.00. Please contact us before this if you would like to set up payment arrangements.
Please let us know today if you have any questions or concerns.

I understand and agree to this financial policy. I have read the financial policy and agree that a photocopy of this financial policy shall be considered as effective and valid as the original. Regardless of what insurance coverage I have, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of insurance benefits to be made directly to Devenir Aesthetics.

______________________________	______________________________
Patient Name (Print)	Patient Signature
______________________________	______________________________
Responsible Party (Print) (If different from patient)	Responsible Party Signature (If different from patient)