



NEW PATIENT INFORMATION
Dr. H.E. Morales ▪ Dr. R. John Fox ▪ Dr. Dale Schaefer

Patient Name: _____ Date: _____
Date of Birth: _____ Age: _____ Male Female
Address: _____ City/State: _____
Home Phone: () _____ Zip Code: _____
Cell Phone: () _____ Employer: _____
Primary Care Physician: _____ Marital Status: Single Married Divorced Widowed

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: _____

MEDICAL HISTORY

Please indicate whether you have had any of the following during the last 12 months.

Head, Eyes, Nose, Throat

Do you wear glasses and/or contacts Yes/No
Do you have glaucoma or cataracts Yes/No
Do you have difficulty hearing Yes/No
Do you have problems with your teeth/gums Yes/No

Musculoskeletal

Are you handicapped in any way Yes/No
Had knee/hip replacement Yes/No
Other Replacements Yes/No

Respiratory

Do you have asthma Yes/No
Do you have emphysema Yes/No
Do you have shortness of breath without exertion Yes/No

Gastrointestinal

Are you troubled with heartburn Yes/No
Is it difficult or painful to swallow Yes/No
Have you ever had a stomach ulcer Yes/No

Cardiovascular

Do you have high blood pressure Yes/No
Does your heart ever beat fast or irregularly Yes/No
Have you ever had a heart attack Yes/No
Are you troubled with swollen feet or ankles Yes/No
Have you had a heart valve replacement Yes/No
Have you ever fainted or felt faint Yes/No
Do you have mitral valve prolapse Yes/No
Do you have a pacemaker Yes/No

Endocrine

Do you have blood sugar problems Yes/No
Do you have thyroid problems. Yes/No
Do you tend to be too hot or cold Yes/No
Do you sleep too little or too much Yes/No

Neurological

Had history of headache/seizures Yes/No
Have you had a stroke Yes/No

Genitourinary

Have you had urinary infections Yes/No
*Do you have regular periods Yes/No
*Number of Pregnancies _____
*Number of Deliveries _____

Integumentary

Do you have skin rashes Yes/No
Does your skin itch or burn Yes/No
Have you had hair loss or nail changes Yes/No
Have you had any skin cancers Yes/No
Do you have rough or raised scars Yes/No

HAVE YOU HAD ANY OF THE FOLLOWING?

Diverticulosis Yes/No
Hepatitis (jaundice or liver disease) Yes/No
HIV/AIDS Yes/No
Cancer Yes/No
Tuberculosis Yes/No
Asthma Yes/No
Hay Fever Yes/No
Diabetes Yes/No
Thyroid Disease Yes/No
Eczema Yes/No
Keloid Scars Yes/No

Please Explain

HAVE YOU HAD ANY OF THE FOLLOWING? (Continued)

Psoriasis Yes/No
Herpes (fever blisters, cold sores, shingles, genital) Yes/No
Varicose Veins Yes/No

Please Explain

FAMILY HISTORY: Does anyone in your family (father, mother, brothers, sisters) have a history of the following:

Diabetes Yes/No
Psoriasis Yes/No
Hay Fever Yes/No
Asthma Yes/No
Eczema Yes/No
Herpes (fever blisters, cold sores, shingles, genital) Yes/No
Skin Cancer Yes/No
Melanoma Skin Cancer Yes/No
Varicose Veins Yes/No

SOCIAL HISTORY: Do you do any of the following:

Use alcohol Yes/No If yes, how many: _____ per day, _____ per week, _____ per month
Use tobacco products Yes/No If yes, how many: _____ per day, _____ per week, _____ per month
If ever, when did you stop? _____

PAST MEDICAL HISTORY:

List all medication allergies: _____

List present medications: _____

Previous Surgical Procedures: _____

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.

Continued...

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)