

MEDICAL/SURGICAL HISTORY

HEIGHT: _____ WEIGHT: _____

DRUG-RELATED ALLERGIES OR INTOLERANCES

CURRENT PHYSICIANS (please include name and specialty)

CURRENT MEDICATIONS (please include over the counter, aspirin or aspirin-containing, birth control, diet, vitamins, or herbal medications)

PREVIOUS SURGERIES OR PROCEDURES (please include procedure and date)

MAJOR INJURIES OR HOSPITALIZATIONS (if not already mentioned above; please include nature of injury and date)

SOCIAL HISTORY (please circle yes or no and fill in appropriate blanks)

Past or Present

| | Yes | No | |
|--------------------------------------|--------------------------|--------------------------|--|
| Tobacco use | <input type="checkbox"/> | <input type="checkbox"/> | _____ packs per day for _____ years; Quit in _____ or current smoker _____ |
| Alcohol use | <input type="checkbox"/> | <input type="checkbox"/> | _____ drinks per day for _____ years; Quit in _____ or current drinker _____ |
| Illicit drug use | <input type="checkbox"/> | <input type="checkbox"/> | What substance? _____ |
| Previous drug or alcohol dependency? | <input type="checkbox"/> | <input type="checkbox"/> | What substance? _____ |

REVIEW OF SYSTEMS

Past or Present

| | Yes | No |
|-----------------------|--------------------------|--------------------------|
| Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Pulmonary trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV/AIDS | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin cancer | <input type="checkbox"/> | <input type="checkbox"/> |

Past or Present

| | Yes | No |
|--------------------------------------|--------------------------|--------------------------|
| Nasal allergy | <input type="checkbox"/> | <input type="checkbox"/> |
| Post-Nasal discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose bleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing through nose | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep Apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use a CPAP? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use vision correcting lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have dry eyes? | <input type="checkbox"/> | <input type="checkbox"/> |

FAMILY HISTORY

Past or Present

| | Yes | No |
|---------------------|--------------------------|--------------------------|
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding Tendencies | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital Defects | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attacks | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Strokes | <input type="checkbox"/> | <input type="checkbox"/> |
| Suicide | <input type="checkbox"/> | <input type="checkbox"/> |

| | Yes | No |
|---|--------------------------|--------------------------|
| Previous exposure to HIV? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you ever get fever blisters or cold sores? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a reaction to anesthetics? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a history of increased bleeding tendency? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been under the care of a psychiatrist? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a history of bad scarring? | <input type="checkbox"/> | <input type="checkbox"/> |
| Does your weight fluctuate significantly? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you pregnant or planning for an upcoming pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken Accutane? When? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had Botox/fillers? When? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

What do you currently use for sunscreen and skin care?

DEVENIR AESTHETICS POLICIES AND CONSENTS

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.

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.

CONSENT AND RELEASE FOR USE OF PHOTOGRAPHS, DIGITAL IMAGES, AND/OR VIDEOTAPES

I hereby authorize the providers at Devenir Aesthetics, aided by such assistants, photographers, or technicians as they may engage for this purpose, to take such photographs, digital recordings, and/or videos of me as they may desire at this time and before, during, and after any operation or procedure which is to be performed on me (or my dependent). I further grant these providers the ongoing and unrestricted right to use the undersigned’s images for general information, education, scientific, medical, and research purposes or for any other purpose which they may deem fit with the understanding that the image will never be identified by name. The images may be conveyed or displayed for those purposes through electromechanical means, including the Internet. I hereby give these providers the right and unrestricted permission to use, reproduce, or publish all such images, and I relinquish all right, title, and interest in these images to Devenir Aesthetics and its providers. I may revoke this consent in writing, delivered to Devenir Aesthetics. Such revocation shall therefore be effective as to any further use not already committed to by these providers. This consent is in consideration of services performed and consultations conducted or to be performed or conducted by the providers at Devenir Aesthetics. There have been no representations or inducements concerning this consent, except as set forth herein.

AGREEMENT CONCERNING ELECTRONIC IMAGING

In the course of consultation, I may have been shown or may be shown pictures on an electronic imaging device. I understand that those pictures and alterations of those pictures are solely for the purposes of illustration and discussion. I understand that the outcome of the procedure is directly related to individual characteristics. I understand that because of the significant differences in how living tissue reacts to surgery, there may be no relationship between the electronic images and final surgical results.

I understand and agree to these policies and consents. I have read this document and agree that a photocopy of it 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)