Austin Cosmetic Medspa
THE ART AND SCIENCE OF AESTHETIC MEDICINE
BY CHRISTINE FISHER MD

New Patient Form — Aesthetic Medical History

Name: _____ Date of birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Occupation: _____ Referred by: _____
Emergency Contact: _____ Phone: _____
Do you have a primary care physician?

Name: _____Phone number: _____

Do you have a preferred pharmacy?

Place: _____Phone number: _____

Insurance and Policy Holder Information

Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Our office does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

Primary Insurance Company: _____
Policy #_____ Group #_____
Insurance Company Address: _____
City_____State_____Zip Code_____
Insurance Company Phone:_____ Policy Holder Relationship:_____

Reason for Consultation: What would you like to see improved?

- ☐ acne
- ☐ wrinkled earlobes
- ☐ brown spots/sun damage
- ☐ decreased lash volume/thickness
- ☐ deep folds around the mouth
- ☐ double chin
- ☐ flat or hollowed cheeks
- ☐ grinding/clenching teeth at night
- ☐ large pores
- ☐ melasma
- ☐ sunken eyes or eye bags
- ☐ thinning eyebrows
- ☐ thinning lips or lip lines
- ☐ neck lines or neck bands
- ☐ redness or facial vessels
- ☐ scars
- ☐ skin laxity (face or body)
- ☐ skin texture
- ☐ soft jawline
- ☐ soft or dimpled chin
- ☐ spider veins
- ☐ stress incontinence
- ☐ stretch marks
- ☐ unwanted hair
- ☐ vaginal laxity or dryness
- ☐ wrinkles around the eyes/forehead

What aesthetic treatments have you had before? _____

_____

Questions About Your Skin

1. How long have you been concerned about this problem? _____
2. When did you notice it? _____
3. Is it getting more pronounced? ☐ Yes ☐ No
4. Have you ever been treated for it before? ☐ Yes ☐ No
    a. When? _____
    b. Method used? _____
5. Are you currently taking medicine for it? ☐ Yes ☐ No
    a. If yes, what is it? _____
6. What topical skin medications or products do you currently use? ☐ Retin-A ☐ Retinol ☐ Hydroquinone/bleaching cream ☐ Other: _____
7. Have you ever had laser/IPL hair removal? ☐ Yes ☐ No
8. Have you used the following hair removal methods in the past six weeks? ☐ shaving ☐ waxing ☐ electrolysis ☐ plucking/tweezing ☐ threading ☐ depilatories
9. Have you ever had skin resurfacing or chemical peels? ☐ Yes ☐ No
10. Do you form thick or raised scars (keloids) when you heal? ☐ Yes ☐ No
11. Do you experience hyperpigmentation from burns, cuts, insect bites? ☐ Yes ☐ No
12. Have you ever had cold sores or fever blisters? ☐ Yes ☐ No

Skin Type

When exposed to the sun for about 1 hour with no protection you tend to:

- ☐ Always burns, never tans
- ☐ Always burns, sometimes tans
- ☐ Sometimes burns, always tans
- ☐ Rarely burn, always tans
- ☐ Brown, moderately pigmented skin
- ☐ Black, darkly pigmented skin

When were you last exposed to the sun or a tanning booth? _____

Do you use self-tanners? ☐ Yes ☐ No

Are you planning a vacation in the sun soon? ☐ Yes ☐ No

Skin Care

What does your current skin care routine include? What products do you use?

_____

_____

Austin Cosmetic Medspa
THE ART AND SCIENCE OF AESTHETIC MEDICINE
BY CHRISTINE FISHER MD

Personal History

Do you use nicotine products? ☐ Yes ☐ No If yes, kind and frequency:_____

Do you drink alcohol? ☐ Yes ☐ No Frequency/amount: _____

Do you wear contact lenses? ☐ Yes ☐ No

Medical History

1. Do you have any of the following?

☐ arthritis
☐ any active infection
☐ bleeding disorders
☐ bruising
☐ diabetes
☐ epilepsy or seizures
☐ heart disease
☐ hepatitis
☐ Autoimmune Disease
☐ herpes simplex
☐ high blood pressure
☐ hormone imbalance
☐ HIV/Aids
☐ melasma
☐ MRSA history
☐ neuromuscular disease
☐ permanent makeup/tattoo
☐ sensitive teeth
☐ skin cancer or unusual moles
☐ skin injury
☐ vision deficits
☐ vitiligo

2. Are you pregnant or trying to become pregnant?
   ☐ Yes ☐ No
3. Are you currently breastfeeding?
   ☐ Yes ☐ No
4. Do you have allergies to any of the following? (check any that apply)
   ☐ sulfa ☐ latex ☐ cow's milk ☐ anesthesia ☐ other: _____
5. Please list any medications you take:
   _____
   _____
   _____
6. Are you taking herbal supplements or vitamins? ☐ Yes ☐ No If yes, please list:
   _____
7. Have you had any dental work in the past month or are you planning any dental work within the next month? ☐ Yes ☐ No If yes, please list:
   _____

I have answered these questions to the best of my knowledge. I understand that it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs.

Patient Signature: _____ Date: _____

Consent for Treatment:

I voluntarily give my permission to the health care provider(s), associates, and such assistant(s) as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from the physician and associates, or until I withdraw my consent in writing.

Statement of Financial Responsibility/Assignment of Benefits:

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Austin Plastic & Reconstructive Surgery/Austin Cosmetic Medspa. I assign and authorize payments to Austin Plastic & Reconstructive Surgery/Austin Cosmetic Medspa. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

Notice of Privacy Policy:
As our patient, you have entrusted your medical information to our care. We know that your relationship with us is based on trust, and that you expect us to act in your best interested. As your personal medical history is your private information, we hold ourselves to the highest standards in its safekeeping. Your signature acknowledges that you have received our Notice of Privacy Policy, which describes how medical information about you may be used and disclosed and how you can get access to this information.

Patient or Guardian Signature: _____ Date: _____

Photo Consent for Clinical Documentation Purposes

Patient _____ Age_____

Note: Your signature below DOES NOT authorize your photos to be used publicly for advertising, marketing, or social media purposes in print and online. (Should you choose to allow your photos to be used by the practice for these purposes, you will sign a separate consent form.)

I authorize Austin Plastic & Reconstructive Surgery, Austin Cosmetic Medspa, and office staff ("Authorized Parties") to take pre-, intra-, and post-operative photos during the course of my evaluation and treatment to be stored in my medical records and **used for the following clinical purposes ONLY:**

- Clinical documentation for pre-surgery planning and post-surgery care
- Testing, credentialing, and routine chart audits with the American Board of Plastic Surgeons

I understand that the photos may be stored in electronic and paper medical records. As able, patient identifying features are excluded.

Patient or Guardian Signature: _____ Date: _____

Financial Policy

Thank you for choosing **Austin Plastic & Reconstructive Surgery** and **Austin Cosmetic Medspa**! We are committed to the success of your medical treatment and care. Please understand that a mutual financial understanding is part of our relationship. We sincerely hope that by sharing our financial expectations we will strengthen the practice-patient relationship and keep the lines of communication open. This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact our office at 512-815-0123.

Payment is Due at the Time of Service

- We accept cash, checks, debit, and credit cards. We are pleased to offer financing through CareCredit.
- All co-payments, deductibles and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment.
- Insurance required co-payments are due when you check in for your appointment. If you arrive without your co-payment, we may ask you to reschedule. We charge an administration fee of $25.00 for co-payments not paid at the time of check in.
- Patient-responsible balances are due when you check in for your appointment, unless prior arrangements have been made with the billing department.
- In order to secure your cosmetic surgery date, we will collect a deposit of a minimum of $500.

Appointment Cancellations and No-Show Policy

- For appointments related to **surgical procedures, non-surgical aesthetic treatments,** and **areola and permanent makeup tattoo appointments**, we request that at least a **72-hour** advance notice be given to the office if you will be unable to keep your scheduled appointment. **All cancellations with less than 72 hours' notice and no-shows will be charged $50.00 per occurrence.** At the time of scheduling your non-surgical aesthetic treatment, we will hold a credit card on file; your card will only be charged if you no-show or cancel your appointment with less than 72 hours' notice. Patients will be expected to pay the $50.00 fee prior to, or at the time of their next appointment. If we need to bill you (in the case where we do not have a credit card on file), a $20.00 administrative fee will be applied in addition to the cancellation/no-show fee of $50.00. Patients who repeatedly "no show" for appointments may be discharged from the practice.

Insurance

- Please bring your insurance card(s) and a valid photo ID with you to each appointment.
- It is your responsibility to notify the practice of changes in your health insurance.

Reconstructive Revisions

The first revision surgery for patients is a covered service by insurance. Subsequent revision(s) are considered cosmetic and are an out-of-pocket cost unless discussed prior to surgery with your surgeon.

- Revisions of other providers' patients will be considered on a case-to-case basis.

Self-Pay Accounts

We designate accounts **Self-Pay** under the following circumstances: (1) patient is covered by an insurance plan that Dr. Fisher does not participate in, (2) patient does not have a current, valid insurance card on file,

(3) patient does not have a valid insurance referral on file, (4) patient does not have health insurance coverage, or (5) patient is having an elective procedure.

Referrals

If you have an HMO plan that we participate in, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, call your primary care physician to obtain it. **If you are unable to obtain the referral at that time, you will be rescheduled** or asked to pay for the visit in advance.

Financial Assistance

Our Practice treats patients regardless of financial status. Please talk to our staff about your financial plan options with our practice.

High Deductible Insurance Plans

- If you have a high deductible insurance plan there may be a balance after your procedure. Please discuss this with our care team to get information on payment plan options.

Billing, Payments and Refunds

- All balances are due in full within 30 days of the statement date. If you cannot pay the balance in full within 30 days, please contact our billing department to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will issue a refund only if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.
- We reserve the right to report delinquent accounts to credit bureaus, assess a collection fee, take other collection action, or terminate you as a patient of this practice.

Questions

Please notify us in writing or by phone if you have questions or concerns.

Austin Plastic & Reconstructive Surgery
2905 San Gabriel Street Suite 100
Austin, TX 78705
Phone: (512) 815-0123
Email: info@austinprs.com

My signature below indicates I accept the terms and conditions of this Financial Policy.

_____ _____

Signature Date

_____

Name (Print)