AUSTIN FACE & BODY

| Today's Date: | Reason for Today's visit: |
|---|---|

**COSMETIC PATIENT REGISTRATION FORM**

| Patient's last name: First: | Middle: | DOB: |
|---|---|---|

| Address: | City: | State: | Zip: |
|---|---|---|---|

| Email Address: | Cell phone no.: | ☐ MALE ☐ FEMALE |
|---|---|---|

**MEDICAL HISTORY**

Drug allergies: ☐ NONE ☐ OTHER: _____ Latex Allergy ☐ YES ☐ NO ALLERGY TO LIDOCAINE ☐ YES ☐ NO

CONTACT SKIN ALLERGIES : ☐ YES ☐ NO IF YES PLEASE DESCRIBE : _____

MEDICATIONS (Include all ocular and over-the-counter medications, vitamins and herbal supplements)

1)_____ 2)_____ 3)_____ 4)_____ 5)_____

6)_____7)_____8)_____9)_____10)_____

**MEDICAL HISTORY:** ☐ Arthritis ☐ Asthma ☐ Lung Disease ☐ Diabetes ☐ Thyroid Disease ☐ Kidney Disease ☐ HIV ☐ H/O PACEMAKER ☐ BLEEDING DISORDER ☐ Liver disease (hepatitis ☐ High Blood Pressure (hypertension) ☐ Irregular heart rhythm (atrial fib, heart block) Gastroesophageal reflux disease (GERD) ☐ LUPUS ☐ MS ☐ STROKE ☐ RADIATION ☐ CHEMO ☐ AUTOIMMUNE DISEASE ☐ SEIZURES ☐ HEPATITIS ☐ NUERO MUSCULAR DISORDER ☐ Heart Failure (congestive heart failure) OTHER: _____

**SURGICAL HISTORY: PLEASE LIST ALL PRIOR SURGERIES, MEDICAL AND COSMETIC:**

1)_____2)_____3)_____

4) _____5)_____6)_____

7)_____8) _____9)_____

**PHARMACY NAME & PHONE NUMBER *REQUIRED*:**

_____

**HOW DID YOU HEAR ABOUT US?** ☐ INFLUENCER ☐ INSTAGRAM ☐ REALSELF ☐ GOOGLE ☐ OTHER _____

**REFER A FRIEND**

If you refer a friend and they book with us, you will get 10% off your next treatment

Name: Email: Phone:

**IN CASE OF EMERGENCY**

| Name of local friend or relative: | Relationship to patient: | Home phone no.: | Work phone no. |
|---|---|---|---|
| | | | |

**Patient/Guardian signature: _____ DATE:_____**

AUSTIN FACE & BODY

**WHAT BRINGS YOU IN FOR A VISIT TODAY?**

_____

_____

**SKIN HISTORY**

***WHAT WOULD YOU CONSIDER YOUR SKIN TYPE?*** ☐ DRY ☐ OILY ☐ COMBINATION ☐ SENSITIVE

☐ UNSURE OTHER: _____

***WHAT PRODUCTS ARE YOU CURRENTLY USING?*** Face wash _____

DAILY ROUTINE _____NIGHTLY ROUTINE_____

DO YOU HAVE ANY ACTIVE SKIN DISORDERS?

☐ PSORIASIS ☐ ECZEMA ☐ OTHER: _____

ARE YOU PREGNANT, OR TRYING TO GET PREGNANT? ☐ YES ☐ NO

ARE YOU CURRENTLY BREASTFEEDING? ☐ YES ☐ NO

***HAVE YOU USED ANY OF THE FOLLOWING TOPICAL|ORAL MEDICATIONS WITHIN THE PAST 30 DAYS?***

☐ ACCUTANE|TRETINOIN ☐ HYDROQUINONE ☐ RETIN-A ☐ VITAMIN A ☐ HYDROXY ACIDS ☐ TOPICAL ANTIBIOTICS

***ARE YOU PRONE TO COLD SORES OR FEVER BLISTERS?*** ☐ YES ☐ NO

IF YES, ARE YOU CURRENTLY TAKING MEDICATION? _____

WHEN WAS YOUR LAST OUTBREAK? _____

DO YOU WHERE SUNSCREEN DAILY? ☐ YES ☐ NO

ARE YOU PRONE TO THICK RAISED SCARS (KELOIDS)? ☐ YES ☐ NO ☐ UNSURE.

ARE YOU PRONE TO HYPERPIGMENTATION? ☐ YES ☐ NO ☐ UNSURE.

DO YOU TAN IN A TANNING BED? ☐ YES ☐ NO

***PLEASE CHECK ALL THE PRIOR TREATMENTS YOU HAVE RECEIVED***

☐CHEMICAL PEEL ☐DERMAFILLERS ☐ NEUROTOXIN ☐HALO LASER ☐ IPL PHOTO FACIAL ☐BBL LASER ☐ SKIN PEN ☐ MORPHEUS ☐ PRP FACIAL

## BODY HISTORY

***ARE THERE AREAS OF CONCERN ON YOUR BODY YOU WISH TO ADDRESS? ☐ YES ☐ NO***

☐ STRETCH MARKS ☐ CELLULITE ☐ SURGICAL SCARS ☐ EXCESS FAT ☐ CREPEY SKIN ☐ SKIN LAXITY

☐BREAST ENHANCEMENT (AUGMENTATION) ☐ MOMMY MAKEOVER ☐BRAZIALIAN BUTT LIFT ☐FACELIFT

☐ RHINOPLASTY ☐ BLEPHAROPLASTY (EYES) ☐ BODY CONTOURING | AB ETCHING ☐ LIPOSUCTION

DESCRIBE YOUR BODY CONCERNS:

_____

_____

_____

LIST ALL PRIOR COSMETIC SURGICAL PROCEDURES:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

***ARE YOU INTERESTED IN COSMETIC SURGICAL INTERVENTION FOR YOUR CONCERNS? ☐ YES ☐ NO***

## SOCIAL HISTORY

DO YOU SMOKE OR VAPE? IF SO, HOW OFTEN AND FOR HOW LONG?

_____

DO YOU CONSUME ALCOHOL? IF YES, HOW OFTEN AND HOW MUCH?

_____

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

ADDITIONAL INFORMATION YOU WOULD LIKE TO DISCLOSE REGARDING YOUR GOALS?

_____

_____

_____

_____

_____

_____

# FREQUENTLY ASKED QUESTIONS REGARDING HIPAA

In a constantly changing healthcare environment, **AUSTIN FACE & BODY** is committed to educating their patients about healthcare issues that affect them. As a result, they have provided general information about the Health Insurance Portability and Accountability (HIPAA) of 1996 for your review. **AUSTIN FACE & BODY** is complying with HIPAA regulations and will be happy to answer any additional questions you might have.

**WHAT IS THE PRIVACY RULE?**

The Privacy Rule is part of the HIPAA regulation of 1996. The Privacy Rule establishes a federal requirement that doctors, hospitals or other healthcare providers and health plans obtain a patient's written consent before using or disclosing a patient's personal information to carry out treatment, payment or healthcare operations.

**WHAT IS PROTECTED HEALTH INFORMATION (PHI)?**

Protected Health Information (PHI) means any personal health information as defined by law, including demographic information collected by healthcare provider or other entity that could potentially identify the individual. PHI includes all medical records and other individual's identifiable health information held or disclosed by **AUSTIN FACE & BODY** regardless of how it is communicated (e.g., electronically, written verbally).

**WHAT IS TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS (TPO)?**

TPO refers to the treatment, payment or healthcare operations of **AUSTIN FACE & BODY**. In other words, quality patients care; ensure that the physician is paid for services; and, operate the business. Some examples of these activities are use of PHI by the physician and clinical staff to treat a patient use; use of PHI by administrative staff for strategic planning and internal management activities.

**WHY DO I HAVE TO SIGN A CONSENT FORM?**

In order to use or disclose your PHI, **AUSTIN FACE & BODY** is required to obtain a signed consent form from you to directly treat you or carry out healthcare payment and business-related activities**. AUSTIN FACE & BODY** is not required by law to treat you, or when there are substantial communication barriers. **AUSTIN FACE & BODY** reserves the right to refuse to treat you if you do not sign the consent form.

**WHAT IS THE DIFFERNCE BETWEEN CONSENT AND AUTHORIZATION FORMS?**

In order to use or disclose your PHI for specific purpose, other than direct treatment, payment, or healthcare operations, **AUSTIN FACE & BODY** is required to obtain a signed authorization form from you. For example, if you request **AUSTIN FACE & BODY** to disclose PHI to a third party, you must an authorization form. This authorization form is more detailed than a consent form and has a specific expiration date.

AUSTIN FACE & BODY

**PATIENT RECEIPT OF "NOTICE OF PRIVACY PRACTICES"**

**AUSTIN FACE & BODY** has provided information regarding the NOTICE OF **PRIVACY PRACTICES**. This notice describes the practice's commitment to privacy, my rights to privacy and how **AUSTIN FACE & BODY** may use and disclose protected health information (PHI) about me to carry pit treatment, payment and healthcare operations.

By signing this form, I am acknowledging that I have reviewed the Notice of Privacy Practices which explains how my medical and personal information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

---

**Patient Name (Printed)**

_____

**Signature of Patient/Personal Representative** **Date**

_____

**Relationship to Patient**

# General Office and Financial Polices

Please initial the lines below AFTER reading the following carefully:

**Financial Responsibility:**

I understand the procedure(s) I seek are cosmetic in nature, not medically necessary, and therefore will not be covered by medical insurance. I understand I will be fully responsible for the treatment, procedures, and or surgery I seek. I understand that if collected, my consultation fee will go towards my treatment, procedure, services rendered.

I understand a non-refundable booking deposit of $500 must be paid to schedule certain procedures and that the remaining balance for those procedures must be paid in full 1 week prior.

**Initial here: _____**

**Cosmetic Surgery Financial Agreement:**

I understand that with cosmetic surgery, I am responsible for the surgical fees quoted to me, as well as additional fees for anesthesia, facility (OR), and possibly laboratory, X-ray, and pathology fees. Surgery centers, Outpatient Centers and Hospitals often have rules that certain tissue /implants removed during surgery must be sent for evaluation that may result in additional fees. Please check with your surgeon for approximate additional costs you will be responsible for.

I understand that there will be a non-refundable deposit for booking and scheduling this surgery which is a part of the overall surgical fee.

**Initial here: _____**

**Patient Consent for use of Credit Cards, Debit Card, and Financing:**
Services that are performed and are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this noncredit card challenge agreement is irrevocable.

**Initial here: _____**

**CANCELLATION / MISSED APPOINTMENTS POLICY**

If you are unable to keep your scheduled appointment, please give our office a minimum of 24 hours' notice so we can accommodate another patient in your time slot. If you fail to do so, a no-show fee will be applied accordingly ($50 for new patients and $25 for return/follow-up patients). Please note that there will be a $100 fee if you are scheduled for any procedure/testing and you fail to provide at least 48-hour notice of cancellation of your appointment.

**Initial here: _____**

**MEDICAL RECORDS AND FORMS**

A form to request transfer of your medical records to our clinic is available on our website. To send your records from our clinic to another physician, we need a written request from you. We require appointment for completion of forms (FMLA, insurance screening, prior authorizations, etc.). If forms are sent or dropped off at our office to be completed on your behalf, a fee of $25 will be due before the form can be processed. You should allow 7 days for completion of any forms.

**Initial here: _____**

**PRESCRIPTION REFILLS AND PREAUTHORIZATIONS**

Prescriptions are typically given at office visits with enough refills to last until your next follow-up visit. You should inform the medical assistant at the BEGINNING of your visit about refills you need**. Please make sure that the pharmacy on file for you is correct**. If a refill is needed sooner, you should contact your pharmacy so the refill can be requested electronically. If your insurance company requires a preauthorization for your medication, you can discuss options for a different medication with your pharmacist or insurance and have them contact us to request a change. We do not have access to your insurance company formulary (list of approved medications). If there is paperwork to be filled out, you may be required to be seen at a regular office visit so the appropriate documentation can be sent to your insurance.

**Initial here: _____**

**CONTROLLED SUBSTANCE POLICY**

Controlled substances include narcotic pain medications, some anti-anxiety medications, attention-deficit medications and some sleep medications. These medications can be habit-forming if misused and extremely dangerous/lethal when combined with certain other medications.

The physicians at Austin Face & Body ***do not prescribe chronic pain medications***. If your condition warrants repeated use of pain medications, you will be referred to a Pain Management Specialist.

The physicians at Austin Face & Body ***do not prescribe benzodiazepines (anxiety meds) for long-term use***. If your condition warrants repeated use of such medications, you will be referred to a Psychiatrist.

Prescriptions for class-2 controlled substances (currently includes hydrocodone for pain and stimulant medications for attention-deficit) must be carried physically by the patient from the office to the pharmacy. Law prohibits these prescriptions from being sent electronically or by fax or mail. Refills for these controlled substances are subject to a $10 administrative fee if there is no office visit at the time the refill is being picked up. Patients prescribed controlled substances agree to urine drug screening on an annual basis; additional urine drug screens may be required at the prescribing physician's discretion.

**Initial here: _____**

***I have read, understand and agree to cooperate with the policies listed above.***

_____ _____

Patient Name / Date of Birth Date

AUSTIN FACE & BODY

# CONSENT TO PHOTOGRAPHY

I hereby authorize photographs to be taken for medical purpose. I agree to the use of the negative, prints, copies or reproductions for insurance documentation, teaching and for monitoring my condition.

_____

***Signature of Patient*** **Date**

If the patient is a minor or unable to sign, complete the following:

Father_____

Mother_____

Guardian or other person/relationship_____