BAY AREA AESTHETIC SURGERY

(650) 570-6066

(Please Print Legibly & Fill In)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Likes to be called (Nick Name) _____

Home Phone _____ Cell Phone _____ Best Phone # for message _____

Any restrictions for contacting you? ❒ No ❒ Yes ***E-mail*** _____

Contact Restrictions: _____

Age _____ Birthdate _____

Marital Status ❒ Single ❒ Married to: _____ : _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

How did you hear about our office? *(Please be specific. Mark all that apply)*

❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Newspaper ❒ Salon ❒ Internet - which site _____

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Areas of Interest: *(mark all that apply)*

Facial Procedures

❒ Blepharoplasty (Eyelid Lift)
❒ Brow Lift
❒ Face or Neck Lift
❒ Facial Liposuction (Neck, Jowls)
❒ Fat Injection
❒ Lip Enhancement
❒ Cheek Implants
❒ Rhinoplasty (Nose Refinement)
❒ Chin Augmentation
❒ Otoplasty (Ear Pinning)
❒ Hair Transplant (Neograft)
❒ Facial Feminization or Masculinzation

Breast Procedures

❒ Breast Augmentation
❒ Breast Lift - Mastopexy
❒ Nipple Reduction or Inversion
❒ Breast Reduction\Gynecomastia
❒ Top Surgery – Chest Masculinization

Body Procedures

❒ Abdominoplasty (Tummy Tuck)
❒ Cellulaze (Cellulite Treatment)
❒ Brachioplasty (Arm Lift)
❒ Liposuction (Thighs, Abdomen, Etc.)
❒ Smart Liposuction
❒ Thigh or Buttock Lift / "Brazilian Butt Lift"

Other Procedures

❒ Laser Hair Removal / Waxing
❒ Smart Skin CO2
❒ Ultherapy (ultrasound skin tightening)
❒ Eyelash Extensions
❒ Dermabrasion / HydraFacial
❒ Skin Care / Skin Resurfacing

Injections

❒ Botox or Dysport
❒ Wrinkle Fillers (unsure of product)
❒ Facial Sculpting
❒ Sculptra
❒ Juvederm or Restylane
❒ Voluma or Restylane Lyft
❒ Kybella (double chin treatment)

OTHER PROCEDURE NOT LISTED: _____

BAY AREA AESTHETIC SURGERY **(650) 570-6066**

(Please Print Legibly & Fill In)

Patient's Name _____
First Middle Last

Purpose of Visit: _____

_____

Previous Surgeries with Dates: *(Including cosmetic procedures)*

_____

_____

_____

Health Problems Past & Present: *(mark all that apply)*

❒ Diabetes ❒ High Blood Pressure ❒ Heart Problems

❒ Easy Bruising ❒ Lung/Breathing Problems ❒ Bleeding/Clotting Problems

❒ Cancer ❒ Psychiatric / Depression

❒ Other: _____

Please explain all positive responses: _____

_____

Do you smoke? ❒ No ❒ Yes, How many packs a day? _____ **Alcoholic Drinks Per Week:** _____

Height _____ **Weight** _____ **Ages of Children** _____

Medications: *(include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)*

_____

_____

_____

Drug or Latex Allergies: *(please indicate if none)*

_____

_____

Primary Physician _____ Phone _____
First and Last Name

Date of Last Physical: _____

Female Patients: *(Please complete)* I am pregnant ❒ No ❒ Yes I am breastfeeding ❒ No ❒ Yes

Are you currently seeing an esthetican? ❒ No ❒ Yes Salon Name: _____ Esthetician: _____

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

PLEASE SIGN

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ Date: _____

Employee signature

FINANCIAL POLICY DISCLOSURE

ACCEPTABLE FORMS OF PAYMENT

- We accept cash, check, Master Card, Visa, American Express and Discover for all services. We do not offer financing, please ask our staff about third-party financing options.
- We do not bill any insurance carrier for any cosmetic service. The patient is responsible for full payment of all services.
- We are not responsible for insurance documentation, reimbursement, denials, appeals, etc.
- Under certain cases we will submit prior-authorizations to insurance companies. Please ask our patient coordinator for information about medically necessary insurance procedures and policies.
- A $25 service fee is assessed on all returned checks. Payment of this fee and all past due amounts must be received prior to receiving any additional services from our office.

INITIAL CONSULTATION FEES

- We ask that you provide a valid credit card at the time you call to schedule your initial appointment. Our standard consultation fee is $150.00 which can be applied to the cost of surgery. If you do not have a credit card, you may send a check as prepayment of your consultation fees to secure your appointment.
- **Consultation Fee may, under certain circumstances, be waived.**

LATE CANCELLATION & No-Show FEE: $150

- CONSULTATION: If you fail to show for your appointment or give less than twenty four (24) business hours notice prior to your appointment time you will be charged.
- AESTHETICIAN SERVICES, NEURORELAXERS and DERMAL FILLERS: Fees for neurorelaxer injections are based upon the number of areas treated. Your practitioner will determine how many areas and how much is needed to achieve your desired outcome. Dermal fillers come in pre-filled syringes for individual patient use. If you fail to show for your appointment or give less than twenty four (24) business hours notice prior to your appointment time you will be charged.

FEES FOR SURGERY

- A DEPOSIT is paid at the time you schedule your surgery. The total balance of the surgery fees are due three (3) weeks prior to the date of your surgery.
- You may elect to add additional service to your surgery package up to seven (7) days prior to the date of your surgery; however, payment will be collected immediately.
- Patients who cancel their surgery will be responsible for a non-refundable processing fee of $500.
- Patients who cancel their surgery with less than twenty-one (21) calendar days notice prior to the date of their procedure will forfeit their entire deposit amount.
- Rescheduling or Rebooking surgery within three (3) weeks of surgery may incur a non-refundable administrative fee.

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have read this document in its entirety. I further agree to the terms of this agreement. I understand that I may request and receive a copy of this document. I understand that office visit charges are payable on the day service is rendered.

_____

Please print your last name, first name

_____ _____

Patient Signature *Date*