COSMETIC PATIENT REGISTRATION

THE SKIN WELLNESS CENTER

Date _____ Provider _____

Patient's Full Name (legal)_____Patient# _____

Address_____City_____State_____Zip _____

Home Phone _____ Work _____Cell Phone _____

Primary Phone Number: Home □ Work □ Cell □

Where may we leave messages? Home □ Work □ Cell □

Email _____
**To receive emails about our specials, please visit our website at theskinwellnesscenter.net to subscribe to our newsletter.

Birth Date _____ SS# _____ Sex: M F Marital Status _____

Occupation_____Employer/School_____Phone_____

Race _____ Preferred Language _____ Ethnicity (Hispanic or Not Hispanic) _____

Notify in Emergency _____ Phone_____ Relationship _____

Primary Care Physician_____

Please note:

Photos of you may be taken before and after each procedure to capture treatment outcomes. Any photos taken will become part of your medical record only and will not be shared or used in any other way without your express written permission.

_____ _____ _____

Signature of Patient or Patient's Representative Relation to Patient Date

COSMETIC CONSULTATION

THE SKIN WELLNESS CENTER

Patient Name _____ Date: _____ Patient # _____

Please mark any services that you want to discuss:		***Please mark any specific problem areas that you want to discuss:***	
◯ Botox	◯ Dermaplaning	◯ 11's (frown lines between the eyes)	◯ Hands
◯ Dermal Fillers	◯ HydraFacial	◯ Crow's Feet	◯ Brows
◯ Laser Treatments	◯ Sclerotherapy	◯ Forehead	◯ Brown Spots/Discoloration
◯ ResurFX	◯ CoolSculpting	◯ Cheeks	◯ Scars
◯ FotoFacial/IPL	◯ Skin Care Products	◯ Lips	◯ Acne
◯ Halo	◯ _____	◯ Face	◯ Leg Veins
◯ BBL	◯ _____	◯ Chin	◯ Thin Eyelashes
◯ Laser Genesis	◯ _____	◯ Chest	◯ Unwanted Fat
◯ SkinTyte	◯ _____	◯ Legs	◯ Facial Veins
◯ Laser Hair Removal	◯ _____	◯ Arms	◯ _____
◯ Chemical Peels		◯ Back	◯ _____

Please list all medications and vitamin supplements you are currently taking:

_____

Please list any medication allergies:

_____

Have you had any sun exposure, used a tanning bed, or used self-tanning products within the last 4 weeks?	_____ Yes _____ No
Are you currently pregnant or nursing or do you think you might be pregnant?	_____ Yes _____ No
Have you been treated with Accutane or similar medication in the past 6 months?	_____ Yes _____ No
Do you have an allergy to sulfa?	_____ Yes _____ No
Do you have a history of herpes/cold sores?	_____ Yes _____ No
Do you have a history of keloids/hypertrophic scarring?	_____ Yes _____ No
Do you have a pacemaker/defibrillator?	_____ Yes _____ No
Do you have any permanent/tattooed makeup?	_____ Yes _____ No
Do you have any metal implants in the area you are interested in treating?	_____ Yes _____ No

What is your current skin regimen? _____

Please list any previous treatments: _____

PLEASE INITIAL EACH LINE BELOW

_____I understand that I am required to pay for products and services rendered at the time of visit.

_____I understand that I have a maximum of 14 days to return products that I am dissatisfied with.

_____I understand that if I arrive late for my appointment I may be asked to reschedule and that no-showing for an appt may result in a no-show fee or loss of deposit.

_____I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices and that I can request this at any time.

_____I understand that minors under the age of 18 must be accompanied by a parent or legal guardian for cosmetic treatments.

Is there anyone you we have permission to speak to regarding your care? _____Relation _____

_____ _____

Signature of Patient or Patient's Representative Date

PRACTICE INFORMATION

THE SKIN WELLNESS CENTER

Patient Name _____ Date _____ Patient # _____

Your Appointment

Your time is important to us. Your appointment time was scheduled based on the **reason you gave us** when you scheduled your appointment. If you have additional problems or need to discuss additional concerns with your provider, we may have to schedule another appointment to address these problems/concerns. This will allow us to be considerate of all our patients' time. **Please bring your insurance card and be prepared to preset it at ***every*** appointment

Cancellation/No-show Policy

We respectfully ask for 24 hours' notice if you will be unable to keep an appointment. Multiple no-shows in a row may result in discharge from the practice.

Not showing for a cosmetic service appointment may incur a no-show fee or loss of deposit.

Late Arrivals

Out of respect for other patients arriving on time, if you arrive late, with or without notice, you may be asked to reschedule. It is at the discretion of your care provider whether you can be worked back into the schedule. Being worked back into the schedule will result in a longer wait time.

Co-pays and Fees for Service

All out-of-pocket charges, co-payments and charges for cosmetic procedures are expected at time of visit.

Your Prescriptions

Unless you request a written prescription to take with you after your visit, prescriptions are sent electronically to your pharmacy. We suggest you call your pharmacy to make sure your prescriptions are ready before going to pick them up.

Insurance companies often change their list of "preferred drugs". We try very hard to keep current with these changes. If your prescription is rejected by your insurance because it is not on their "preferred list", additional time will be required for approval of a substitute medication.

Lab

We participate only with Dermatopathology Partners for all biopsy samples. Your insurance will be billed by Dermatopathology Partners, and you are responsible to Dermatopathology Partners for any balance due after insurance.

For all other labs (blood work, urine samples) we use PathGroup which participates with most insurances. If your insurance plan requires you to use a different lab, please notify us at the time of your visit.

Consent to Treat Minors

Minors, persons under the age of 18, must be accompanied by a parent or legal guardian for all appointments. If it is necessary for a minor to come to appointments alone or with a friend or family member, we must have a statement ***in writing*** from a parent or legal guardian giving us permission to treat your child without the parents' presence.

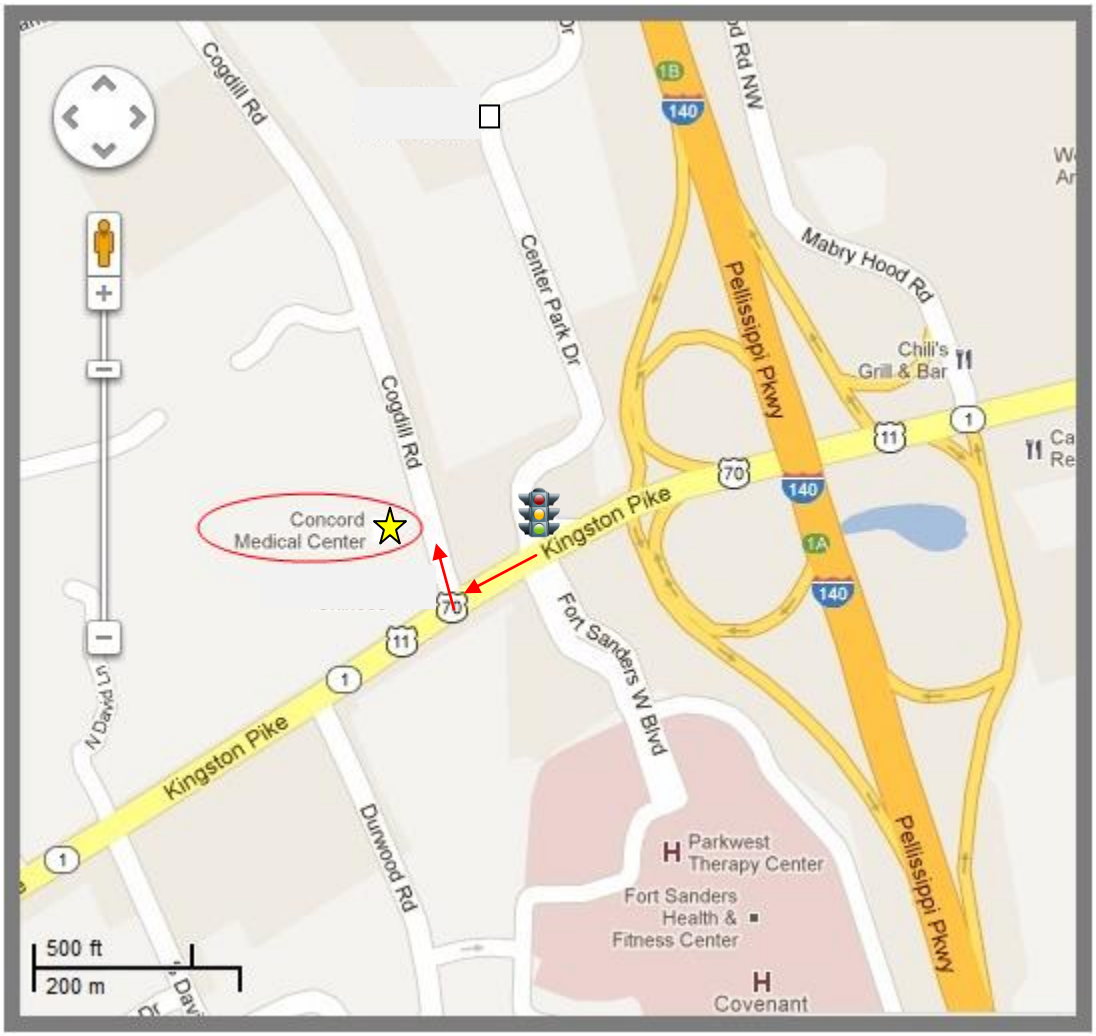
__First visit__: A parent or legal guardian ***must accompany a minor patient to the first visit in our office. We have a form for consent to treat a minor that we can provide upon request for future appointments. The parent that brings the child in for the initial appointment will automatically be the guarantor for the account and must be able to present a photo ID and the patient's insurance card.

I acknowledge that I have read and understand the above statements and all questions have been answered to my satisfaction.

_____ _____

Signature of Patient or Patient's Representative Date

Please tell the receptionist if you would like a copy of this form for your own files.



Our office is located at

10215 Kingston Pike, Suite 200, Knoxville, TN 37922

From **I-40** both East and West

Take **Exit 376B South** toward Maryville

Then take **Exit 1B West** onto Kingston Pike

Go through the red light at Center Park Drive

Turn right on **Cogdill Road**

Our office is located on the left at **Concord Medical Center**

We are on the **2nd floor**