COSMETIC PATIENT REGISTRATION

THE SKIN WELLNESS CENTER

TODAY'S DATE: _____

PATIENT INFORMATION **PATIENT NUMBER:**

FULL NAME		
DOB	SS#	
PREFERRED LANGUAGE	SEX	RACE/ETHNICITY
MAILING ADDRESS (Street, City, State, Zip)		
HOME PHONE May we leave messages? ☐ Y ☐ N	CELL PHONE May we leave messages? ☐ Y ☐ N	
EMAIL *Please visit our website at theskinwellnesscenter.net to subscribe to emails about our specials*		

MARITAL STATUS	SPOUSE NAME	SPOUSE PHONE
OCCUPATION		
EMERGENCY CONTACT NAME		
EMERGENCY CONTACT PHONE	REATIONSHIP TO PATIENT	

MEDICAL CONTACT/RELEASE OF INFO Is there anyone you would like to give us permission to speak to on your behalf?

NAME	RELATIONSHIP

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 not showing for an appointment may result in a no-show fee or loss of deposit. I acknowledge that I have a right to request a copy of the Notice of Privacy Practices at any time.

_____

Printed Name of Patient or Patient's Representative

_____

Signature of Patient or Patient's Representative Relation if Not Patient Date

COSMETIC CONSULTATION

THE SKIN WELLNESS CENTER

TODAY'S DATE: _____

PATIENT INFORMATION **PATIENT NUMBER:**

Full Name	DOB
List all current medications, vitamins, herbals	
List any medication allergies	

Check all that apply:

- ☐ Sun exposure or tanning bed use in the past 4 weeks
- ☐ Currently pregnant or breastfeeding
- ☐ Treated with Accutane or similar in the past 6 mths
- ☐ Allergic to sulfa
- ☐ History of fever blisters/cold sores
- ☐ History of keloid/hypertrophic scarring
- ☐ Pacemaker/defibrillator
- ☐ Permanent/tattooed makeup
- ☐ Metal implants in area interested in treating
- ☐ Dental procedures in last two weeks
- ☐ History of auto-immune disease If so, please list _____
- ☐ Reaction to local anesthesia or topical numbing What type of reaction? _____
- ☐ Sunscreen use ☐ Occasionally ☐ Frequently What SPF? _____
- ☐ Current smoker How much do you smoke?

What is your current skin regimen? ☐ No regular routine

List any previous treatments

I understand that payment for all products and services is due at the time of my visit. I understand that products may be returned within 14 days if I am not satisfied. I understand that arriving late to an appointment may require rescheduling. I also understand that failure to provide at least 24 hours' notice for a cancellation or missed appointment may result in a no-show fee and/or forfeiture of any deposit. I acknowledge that patients under the age of 18 must be accompanied by a parent or legal guardian for all cosmetic treatments.

_____

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Please continue to back side

We are so glad that you chose us! Our #1 priority is meeting your needs and helping you achieve your long-term aesthetic goals. To best serve you, please complete this form. Your aesthetic provider will use this as a guide to help ensure we provide the best patient experience and outcome possible.

What is your favorite facial/neck feature? _____

What is your main aesthetic concern? _____

What is your secondary concern? _____

Do you want to receive a full facial consultation today? ☐ Yes ☐ No ☐ I'd like to learn more about this

Do you feel any of the following when you look in the mirror? ☐ Fatigue ☐ Tired ☐ Sad ☐ Angry

☐ Other _____

What concerns do you want to discuss during your appointment? ☐ Asymmetry ☐ Imbalance

☐ Definition ☐ Sagging skin ☐ Brown spots ☐ Facial redness ☐ Fine lines ☐ Pigmentation

☐ Other _____

What are your expectations for the treatment/visit? _____

Do you have any upcoming events? _____

What bothers you about your facial and neck features?

☐ Gaunt ☐ Lost definition

☐ Sagging ☐ Round

☐ Old ☐ Jowls

☐ Droopy ☐ Angry

☐ Crepey ☐ Dark

☐ Hollow ☐ Sad

☐ Dull ☐ Tired

☐ Sunken ☐ Wrinkles

☐ Puffy ☐ Heavy

☐ Falling ☐ Frowny

☐ Other _____

Mark below all areas of the face and neck that you would like to discuss and/or get treated today.

NEW PATIENT CONSENT AND FINANCIAL POLICY

THE SKIN WELLNESS CENTER

Patient Name _____ Date _____ Patient # _____

Consent to Treat and Financial Policy

- I consent to treatment necessary for the care of the above-named patient.
- I authorize the release of all medical records necessary to the referring or treating physician(s) and to process insurance claims filed on my behalf or that of my dependents.
- I authorize and request that insurance payments be made directly to The Skin Wellness Center.
- I understand that if I do not have insurance at the time of service, I will be financially responsible for full payment of all services rendered.
- I understand that payment of copays, cosmetic treatment, and out of pocket charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- If this account becomes past due, I will be responsible for all reasonable collection service fees. If legal action is required to collect this account, I agree to pay all attorney fees and court costs.

Appointments

- 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.
- Please bring your insurance card and be prepared to present it at every appointment.
- We respectfully ask for 24 hours' notice if you will be unable to keep an appointment.
- I understand that not showing for a cosmetic appointment may result in a no-show fee or loss of deposit.
- Multiple no-shows or cancellations may result in discharge from the practice.

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. To be worked back into the schedule, you must remain in the office until that time.

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 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.
- Obtaining insurance authorization for a medication is a lengthy process and may take several days to weeks to process through insurance. The length of this process is dictated by your insurance provider. We respectfully request your patience when waiting for medication authorizations.

Lab and Pathology

- 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 (bloodwork, urine samples, cultures) we use PathGroup which participates with most insurances.

NEW PATIENT CONSENT AND FINANCIAL POLICY

Minor Patients (under the age of 18)

- Minors must be accompanied by a parent or legal guardian for all appointments.
- After the first appointment, a parent or legal guardian may request to sign a Consent to Treat Minors giving us permission to treat your child without a parent's presence for future appointments.
- **A parent or legal guardian MUST accompany a minor to the first appointment, **no exceptions**.** The parent or legal guardian 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.

Skin Care Product Purchases

- I understand that I am required to pay in full for skin care products at time of purchase.
- I understand that I have a maximum of 14 days to return products that I am dissatisfied with.
- Credit for the returned product(s) may be applied to a new purchase on the same day.

Photos

- I understand that photos of me may be taken for documentation and before and after each procedure to capture treatment outcomes.
- Any photos taken will become part of my medical record only and will not be shared or used in any way without my express written permission.

Acknowledgment of Policies

I acknowledge that I have read and fully understand the above policies and my responsibilities. All questions have been answered to my satisfaction.

_____

Printed Name of Patient or Patient's Representative

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