

PATIENT INTAKE INFORMATION

DATE: ____/____/____

PRIMARY REASON FOR VISIT: _____

MR MRS MISS MS DR OTHER

SEX: MALE FEMALE OTHER

FIRST NAME: _____ **MI:** _____ **LAST NAME:** _____

NICKNAME: _____ PARENT'S NAME (IF PATIENT IS A MINOR): _____

DATE OF BIRTH: ____/____/____ **AGE:** _____ **LANGUAGE PREFERRED:** _____

MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

CELL PHONE: _____ **HOME PHONE:** _____

EMAIL ADDRESS: _____

By entering your email address, you agree to receive emails from RL Center for Cosmetic Surgery & Medspa and/or trusted third parties containing promotions, appointments or other information as needed.

Do you agree to receive internal special offers and discounts via the above email, phone, and text? YES or NO

OCCUPATION: _____ **EMPLOYER NAME:** _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED PREFER NOT TO ANSWER

SPOUSE'S NAME: _____ SPOUSE'S PHONE: _____

EMERGENCY CONTACT: I authorize the release of my personal medical information to the below persons.

MUST list at least one emergency contact.

CONTACT 1 NAME: _____ **PHONE:** _____ **RELATION:** _____

CIRCLE ONE: Emergency Only OR All Information

CONTACT 2 NAME: _____ **PHONE:** _____ **RELATION:** _____

CIRCLE ONE: Emergency Only OR All Information

HOW DID YOU HEAR ABOUT OUR OFFICE?

- Google.com RLCosmeticSurgery.com RealSelf.com Yelp.com
 Social Media Website: _____ Doctor: _____
 Friend / Family: _____ Other: _____

MEDICAL HISTORY QUESTIONNAIRE: Please circle (P) if you, the **Patient**, or (F) a **Family Member** has experienced any of the following:

P F AIDS / HIV	P F Easy Bruising	P F Radiation Treatment
P F Anemia	P F Epilepsy	P F Rashes / Eczema
P F Angina	P F Eye Problems	P F Respiratory Disease
P F Arthritis	P F Fainting	P F Rheumatoid Arthritis
P F Artificial Heart Valves of Joints	P F Foot / Leg Cramps	P F Rheumatic Fever
P F Asthma / Emphysema	P F Facial Implants	P F Rosacea
P F Back Problems	P F Gout	P F Seizure Disorder
P F Bleeding Disorders	P F Headaches	P F Shortness of Breath
P F Cancer	P F Heart Disease	P F Sinus Problems
P F Chemical Dependency	P F High Blood Pressure	P F Skin Cancer
P F Chest Pain	P F Kidney Problems	P F Stroke
P F Chronic Diarrhea	P F Liver Disease	P F Swelling in Hands or Feet
P F Chronic / Frequent Cough	P F Low Blood Pressure	P F Swollen Glands in Neck
P F Circulatory Problems	P F Lupus / Sjögren's	P F Throat Pain
P F Collagen Vascular or Autoimmune	P F Memory Loss	P F Tired Feet
P F Cold Sores	P F Metal Implants	P F Tuberculosis
P F Dentures / Bridges / Loose Teeth	P F Nervousness	P F Ulcers
P F Diabetes	P F Ocular Disease / Surgery	P F Varicose Veins
P F Dry Eyes or Blepharitis	P F Prescribed Vitamin A (Retin A, Renova)	P F Venereal Disease
P F Ear / Hearing Problems	P F Psychiatric Conditions	P F Weight Loss / Gain

List any medical problems or diseases you are being treated for or have been treated for in the past: NONE

PRIMARY CARE PHYSICIAN'S NAME: _____ **PHONE:** _____

OTHER DOCTORS CARING FOR YOU: NONE _____

PHARMACY NAME & LOCATION: _____ **PHONE:** _____

PRIMARY INSURANCE: _____ **SECONDARY INSURANCE:** _____

CURRENT MEDICATIONS: NONE _____

PAST HOSPITALIZATIONS: NONE _____

PAST SURGERIES: NONE _____

Are you allergic to...? Please circle.

Y N Adhesive Tape	Y N Iodine Seafood	Y N Anesthetics	Y N Codeine	Y N Aspirin
Y N Novocaine	Y N Sulfa Drugs	Y N Penicillin	Y N Demerol	Y N Latex

OTHER ALLERGIES: NONE _____

Do you take Accutane or Amiodarone? YES NO

Are you pregnant or nursing? YES NO

Do you smoke? YES NO Number of years: _____ Number of packs per day: _____

Do you consume alcohol? YES NO Amount consumed per week: _____

Current height: _____ **Current weight:** _____ **How often do you exercise?** _____

OTHER PERTINENT HEALTH INFORMATION: NONE

Payment, Billing, Medical Records, & Patient Consent

Appointment Payment Policies

We require 48 hours of notice for appointment cancellations.

A **\$50 deposit** is required to schedule any non-surgical appointments that are less than 60 minutes.

A **\$100 deposit** is required to schedule any non-surgical appointments that are 60 minutes or longer.

OR

A valid credit card must be on file, to which deposits and no-show fees can be charged if and when required.

Once your appointment has been completed, your deposit amount will be applied towards the balance of your final bill.

Should you fail to show up for your appointment, you will be subject to a \$50 or \$100 no-show fee, depending on the duration of the service scheduled?

Unfortunately, **if you arrive more than 15 minutes late**, we cannot guarantee treatment.

Any unapplied payments on the patient account that are not applied to a visit charge (other than a deposit for a scheduled appointment) will be refunded back to the credit card used, or a gift card will be issued for any non-credit card payments. Unapplied payments may not remain on a patient's account for more than six (6) months (this excludes prepayments for packages, surgical deposits, etc.)

We do not accept credit card payments exceeding \$1,000 over the phone.

All treatment and product charges are due at the time of service.

If payment for services cannot be obtained for any reason, charges or balances will be referred to a collection agency. As a result, your full balance will be assessed an additional 30% fee. If litigation is required to collect full payment, additional fees will become the responsibility of the patient.

Patients with any unpaid, outstanding, or delinquent account balances that have been categorized as bad debt or referred to a collection agency may be denied treatment if not deemed medically necessary.

Surgical Financial Policies

For surgery scheduling, we require a **\$1,000 non-refundable deposit** to schedule your procedure. This deposit will be treated as a pre-payment towards your final surgery charges.

Your surgery is required to be paid in full, less deposits, at least **three (3) calendar weeks in advance**.

The surgical deposit is NON-REFUNDABLE. If you cancel your surgery more than six (6) weeks in advance, you can apply the \$1000 deposit to any other surgery, treatment, or product here within six (6) months of the payment date. If you cancel your surgery between three (3) and six (6) weeks in advance, your \$1000 surgical deposit will be forfeited. If you cancel your surgery less than three (3) weeks in advance, 50% of your quoted surgical fees will be forfeited in order to cover the cost of supplies and staffing which were reserved for your surgery.

Billing of Insurance

Most insurance policies pay only a portion of your total charges. If you have questions about your coverage(s) benefits, please contact your insurance provider directly. While we make efforts to conduct benefits eligibility for applicable patients, we do not guarantee the accuracy of benefit information given to us by insurance companies.

I understand that I am ultimately financially responsible for my care. In addition, should the insurance company deem the treatment services I receive medically unnecessary, or if there remains a patient balance due for any reason, it will be my responsibility that balances due are paid in full in a timely manner. I also understand that RL Center for Cosmetic Surgery & Medspa may use collections agencies related to delinquent account balances. Should this occur, I also understand that I am responsible for collection agency fees or attorney fees related to my care.

Retail Sales Items

Retail items are considered exchangeable, **NOT RETURNABLE**, for up to fourteen (14) calendar days after purchase. Any item listed as **"FINAL SALE"** is neither returnable nor exchangeable. This includes, but is not limited to, vitamin supplements, prescription items, Capillus Caps, Omnilux masks, and any items listed as "clearance" sale items.

Medical Records

RL Center for Cosmetic Surgery & Medspa is not responsible for the accuracy or interpretation of any medical record information received from another external physician, practice, or lab. If you request copies of your medical records or require paperwork to be completed related to medical leave, disability, return-to-work clearance or return-to-classroom clearance, **there will be a \$25 charge per request.**

Personal Belongings

RL Center for Cosmetic Surgery and Medspa cannot be held liable for your personal items and belongings.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to RL Center for Cosmetic Surgery & Medspa to use and disclose PHI (Protected Health Information) about me to carry out Treatment, Payment, and health care delivery Operations, otherwise known as TPO. Treatment records named Electronic Medical Records include all documentation of services, consents, and photography. All PHI is covered in this consent.

I have the right to review the Notice of Privacy Practices prior to signing the consent. RL Center for Cosmetic Surgery & Medspa reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy may be obtained by forwarding a written request to management.

With this consent, RL Center for Cosmetic Surgery & Medspa may call my home or alternative location and leave a message in voicemail or in-person with reference to any items that assist the practice in carrying out TPO, including, but not limited to, appointment reminders, insurance items, laboratory test results, and any calls pertaining to my clinical care.

With this consent, RL Center for Cosmetic Surgery & Medspa may mail to my home or another alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, RL Center for Cosmetic Surgery & Medspa may email to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, RL Center for Cosmetic Surgery & Medspa may text to my home or another alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

PHI may be requested by insurance payors to support claims. With this consent we may submit PGI for billing purposes upon request.

Printed Name: _____

Signature: _____ **Date:** _____