

**SANTA ANA SKIN CARE CLINIC  
683-B HARKLE RD  
SANTA FE, N.M. 87505**

**FIRST NAME:** \_\_\_\_\_ **LAST NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**MAILING ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**WORK #:** \_\_\_\_\_ **HOME #:** \_\_\_\_\_

**SS#:** \_\_\_\_\_

**WHO REFERRED YOU TO OUR OFFICE?** \_\_\_\_\_

Thank you for choosing our office for all of your skin care needs. If at any time you have questions regarding your treatment please feel free to call the office. Please note that treatment fees are due at the time of services, and medical insurance does not cover treatments because they are considered a cosmetic luxury. Also note that the results of products and procedures are not guaranteed. Also all products and services offered through Santa Ana Skin Care Clinic are **non-refundable**.

\_\_\_\_\_  
SIGNATURE OF  
RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

# SANTA ANA SKIN CARE CONSULT

Santa Ana Skin Care Clinic

(505) 954-422

\*Are you pregnant? Yes \_\_\_ No \_\_\_ If so we made need to reconsider your treatment needs.

\*Do you have HIV/AIDS? Yes \_\_\_ No \_\_\_ Do you have Hepatitis A/B/C? Yes \_\_\_ No \_\_\_ If yes which one? \_\_\_\_\_

\*Do you wear contact lenses? Yes \_\_\_ No \_\_\_ If yes please remove lenses if your eyes are sensitive or if you are having a microdermabrasion.

\*Do you currently have a sunburn/windburn/red face? Yes \_\_\_ No \_\_\_ If yes we made need to decline treatment for today.

\*Do you currently get facial waxing/electrolysis/or use depilatories? Yes \_\_\_ No \_\_\_ If yes you will need to wait 5 days between treatments.

\*Are you using Biore Pore strips? Yes \_\_\_ No \_\_\_ If yes you will need to discontinue use for 5 days after treatment.

\*Are you currently using Retin-A/Renova/Differin? Yes \_\_\_ No \_\_\_ If yes want strength? \_\_\_\_\_ For how long? \_\_\_\_\_ How frequently? \_\_\_\_\_ Where applied? \_\_\_\_\_

You will need to discontinue use for 5 days before having a treatment done.

\*Are you currently using Accutane? Yes \_\_\_ No \_\_\_ How long? \_\_\_\_\_

\*Are you currently having microdermabrasion? Yes \_\_\_ No \_\_\_ How long? \_\_\_\_\_

\*Do you have regular Collagen/Botox/Restylane injections? Yes \_\_\_ No \_\_\_ If yes the PCA Peel should precede injections by 7 days.

\*What type of work do you do? \_\_\_\_\_

\*Do you travel by airline? Yes \_\_\_ No \_\_\_ How often? \_\_\_\_\_

\*Do you participate in vigorous aerobic activity or sport? Yes \_\_\_ No \_\_\_ What type? \_\_\_\_\_

\*Have you ever had a peel? Yes \_\_\_ No \_\_\_ If yes was it within the last 14 days? Yes \_\_\_ No \_\_\_ What type of peel was it? \_\_\_\_\_ Describe your reaction. \_\_\_\_\_

\*Have you recently had facial surgery? Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_

\*Have you recently had laser resurfacing? Yes \_\_\_ No \_\_\_ If yes when was the procedure done? \_\_\_\_\_ What type was it? \_\_\_\_\_

\*Do you smoke? Yes \_\_\_ No \_\_\_

\*Are you prone to cold sores/fever blisters? Yes \_\_\_ No \_\_\_ If yes when was your last break out? \_\_\_\_\_

\*Are you allergic/sensitive to any of the following? (check all that apply) milk \_\_\_ apples \_\_\_ citrus \_\_\_ grapes \_\_\_ aloe vera \_\_\_ aspirin \_\_\_ perfumes \_\_\_ latex \_\_\_ hydroquinone \_\_\_ lidocaine \_\_\_\_\_

Any other allergies not mentioned? Yes \_\_\_ No \_\_\_ If yes what? \_\_\_\_\_

\*Are you sensitive to alcohol based products? Yes \_\_\_ No \_\_\_

\*Are you taking any medications at this time? Yes \_\_\_ No \_\_\_ If so antibiotics increase sensitivity.

\*Tell me about your skin; describe it for me (check all that apply): thick \_\_\_ thin \_\_\_ saggy \_\_\_ firm \_\_\_ normal \_\_\_ dry \_\_\_ t-zone/combination \_\_\_ oily \_\_\_ acne \_\_\_ comedones \_\_\_ milia \_\_\_ cysts \_\_\_ breakouts \_\_\_ acne scarred \_\_\_ large pores \_\_\_ small pores \_\_\_ flrid \_\_\_ rosacea \_\_\_ eczema \_\_\_ freckled \_\_\_ sun damaged \_\_\_ uneven/blotchy \_\_\_ mature \_\_\_ wrinkled \_\_\_ patchy dryness \_\_\_ sallow \_\_\_ melasma \_\_\_ perfume-stained \_\_\_ hypo-pigmented \_\_\_ hyper-pigmented \_\_\_ psoriasis \_\_\_ dehydrated \_\_\_ asphyxiated \_\_\_ telangiectasia/broken surface capillaries \_\_\_

\*Do you consider your skin sensitive \_\_\_ resilient \_\_\_ not sure \_\_\_ What is your eye color? blue \_\_\_ green \_\_\_ hazel \_\_\_ gray \_\_\_ lt. brown \_\_\_ med. brown \_\_\_ dk. brown \_\_\_ What is your hair color? blonde \_\_\_ red \_\_\_ lt. brown \_\_\_ med. brown \_\_\_ dk. brown \_\_\_ black \_\_\_ gray/silver \_\_\_ white \_\_\_ What is your skin tone? pale/white \_\_\_ light \_\_\_ medium \_\_\_ reddish \_\_\_ freckled \_\_\_ lt. olive \_\_\_ med. olive \_\_\_ dk. olive \_\_\_ lt. brown \_\_\_ med. brown \_\_\_ dk. brown \_\_\_ soft black \_\_\_ black \_\_\_ sallow \_\_\_

\*What is your ethnicity? \_\_\_\_\_

\*Are you using glycolic/AHA home care products? Yes \_\_\_ No \_\_\_ If so which ones? \_\_\_\_\_

\*How does your skin react to them? \_\_\_\_\_

\*Have you ever used any products that caused a bad reaction? Yes \_\_\_ No \_\_\_ If yes please explain. \_\_\_\_\_

\*What is your daily home care regimen? \_\_\_\_\_

\*What are the cosmetic improvements you would like to see in skin? \_\_\_\_\_

I acknowledge that I have answered the above questions true and to the best of my knowledge.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

# PROCEDURE AGREEMENT FORM

- \_\_\_\_ Initials Prior to receiving treatment, I have been candid in healing any condition that may have bearing on this procedure, such as: pregnancy, recent facial surgery, allergies, cold sores/fever blisters use of medication, etc.
- \_\_\_\_ Initials I understand there may be some degree of discomfort, i.e.: stinging, pin pricking, hotness, tightness, etc.
- \_\_\_\_ Initials I understand there are no guarantees as to the results of this treatment, due to Many variables, such as: age, condition of skin, smoking, etc.
- \_\_\_\_ Initials I understand that I may or may not actually peel, that each case is individual.
- \_\_\_\_ Initials I understand that the treatments performed here are considered cosmetic, and there can be no guarantees of insurance payment.
- \_\_\_\_ Initials I understand that to achieve maximum results, I may need several treatments.
- \_\_\_\_ Initials I understand that although complications are very rare, they may still occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor or aesthetician who performed the treatment.
- \_\_\_\_ Initials I agree to refrain from tanning booths while I am undergoing treatment, and during the 21 days following the end of treatment.
- \_\_\_\_ Initials I understand that direct sun exposure is prohibited while I am undergoing treatment, and the use of sun block with a minimum SPF 15 is mandatory.
- \_\_\_\_ Initials I have not had any other peel treatment of any kind within 14 days of this treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or at any other location, unless directly expressed otherwise by the doctor or aesthetician.

**I hereby agree to all of the above statements and have answered true and to the best of my knowledge. I give consent to have treatment performed on me. I further agree to follow all post care instructions as I am directed.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## FINANCIAL POLICY

Please read our financial policy and indicate your agreement by your signature. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. All patients must complete the appropriate information forms before seeing a skin care provider.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE.** (Unless other arrangements are made directly with the office manager.)

We accept cash, check, Visa, American Express, Discover and Master card.

Private pay patients: Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or paid by cash, check, or credit card at the time of services.

Insured patients: If you have insurance we will help you receive maximum benefits. We will give you properly completed "super bills" so that you can file your own insurance and be reimbursed to the extent of your coverage. We only file claims to insurance companies that we are participating providers for. Filing a claim is not a guarantee of payment. Many of our services are considered to be a cosmetic luxury and are therefore not covered by insurance. You are responsible for the full payment of any denied claims.

Insurance: This is a contract between you and your insurance company. In many cases we are not a party to this contract. We will inform you if we are a party to your contract, and we will handle your claims according to our agreement with your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance usual and customary charges, etc. other than to supply actual information as necessary. You are responsible for timely payment on your account.

**Missed appointments: Unless canceled or rescheduled at least 24 hours in advance, our policy is to charge \$50 for missed appointments. Please help us serve you better by keeping scheduled appointments.**

Balance due terms: Your signature below indicates your agreement with our terms for any unpaid balance due. Unpaid balances due will begin accruing interest at the rate of 12% per annum, for balance due over 30 days. If it becomes necessary to employ an attorney or collection agency to collect an unpaid balance due, those fees will be added to the balance due. If you are unable to pay a balance due, please discuss payment arrangements with our office manager.

Please Note: All products and services offered through Santa Ana Skin Care Clinic are non-refundable.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# PRIVACY POLICY

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice summarizes how we handle your information, and provides further details of our privacy policies and procedures.

**How we may use and disclose your information:** We use health information about you for your treatment, to get paid for treatments, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for these reasons. Beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop further uses or disclosures.

**Your rights:** In most cases you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we will charge you a cost-based fee and these copies will be made within 30 days. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

**Our legal duty:** We are required by law to protect the privacy of your health information; provide this notice about our privacy policies; follow the privacy practices that are described in this notice; and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time. Before we make significant changes in our privacy policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

**Privacy complaints:** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

**If you have any questions or complaints, please contact:**

Elena Winters  
683 B Harkle Road  
Santa Fe, NM 87505

(505) 954-4422 ext 1004

Responsible party signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **PROCEDURE CLAIM REVIEW FORM**

Santa Ana Skin Care Clinic would like to make you aware that in the in the event that we should submit a claim to your insurance company for a procedure reviewed here at our clinic, your insurance provider always reserves the right to review and deny any claim they receive. We may be able to find out for you if the procedure does not require a pre-authorization, but these procedures are still subject to review and possible denial. The only time your insurance company is obligated to pay any amount is if they give you a confirmed pre-authorization number which we will keep in your chart making you not responsible for payment; unless the treatment amount is applied towards a deductible then you will still be held responsible for payment. Your signature below indicates you agree to abide by the policy in this form.

I \_\_\_\_\_ have read and understand the Insurance Procedure Claim Review Form.