THE INFORMATION REQUESTED ON THIS FORM IS USED FOR OTHER IMPORTANT DOCUMENTATION. PLEASE PRINT LEGIBLY. THANK YOU

Referring or Primary Care Physician or Friend (**FIRST AND LAST NAME)**	**OR:** How did you hear about us?

PATIENT INFORMATION

Patient's last name:	First:	Middle Int:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Preferred / Nickname:	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street address:					
City:		State:		ZIP Code:	

Occupation:	Employer:	Work Phone #:	Home Phone #:	Cell Phone #:

Person responsible for bill: ***REQUIRED***	D.O.B. ***REQUIRED*** / /	Address (if different):	Home phone #: ( )

Occupation:	Employer:	Employer address:	Employer phone #: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

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 time of services, and medical insurance may not cover treatments because they are considered a cosmetic luxury. Also note that results of products and procedures are not guaranteed. Also, all products and services offered through SASC are **non-refundable**.

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance.

____ _______________________________

Patient / Guardian Signature Date

ALLERGIC TO: ____________________ ____________________ ____________________

AESTHETIC PATIENT SELF-ASSESMENT

Please complete this questionnaire to help us better understand your history, preferences, and concerns with respect to aesthetic treatments and procedures. Your responses will help us identify and recommend the most appropriate treatments and procedures for you.

1. What is the main reason you came in for this consultation?

____
____

2. What aesthetic treatments and procedures, if any, have you had in the past?

____
____

3. If you have previously had any aesthetic treatments or procedures, were you pleased with the outcome?

   ☐ Yes ☐ No

   If no, in what way were you dissatisfied?

   ____
   ____

4. Do you have any concerns about aesthetic treatments or procedures?

   ☐ Yes ☐ No

   If yes, please identify your concerns:

   ____
   ____

AESTHETIC PRODUCTS, TREATMENTS AND PROCEDURES

Please let us know which of the following aesthetic products, treatments, and procedures interest you. Please check all that apply.

- ☐ PCA and Glycolic Peels
- ☐ Skin Rejuvenation
- ☐ Topical Wrinkle Treatment
- ☐ Microdermabrasion
- ☐ Botulinum Toxin Type A
- ☐ Acne Treatment
- ☐ Facial Vein Correction or Removal
- ☐ Mineral Make-up
- ☐ Birthmark Correction
- ☐ Liver Spot / Age Spot Correction
- ☐ Sunscreen Advice
- ☐ Dermal Fillers
- ☐ Leg Vein Correction or Removal
- ☐ Hair Removal
- ☐ Laser Resurfacing
- ☐ Professional Skin Care Products
- ☐ Other (Please Specify): ____

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CANCELLATION / RESCHEDULE / NO SHOW POLICY

Failure to keep scheduled appointments is costly to our practice and to other patients. Patients who are not able to keep their scheduled appointments are required to provide timely notice of reschedule or cancellation prior to their appointment time. (See below.) Providing the required notice gives us the opportunity to schedule patients from a wait list so they may be seen sooner.

Any patient who DOES NOT provide required notification of reschedule or cancellation to the staff at SASC is subject to a Cancel / Reschedule / No Show Fee that is not covered by insurance companies.

Due to the nature of services provided, required no-show fees and required notice varies by treatment length. Patients will be informed of fee requirements when appointments are confirmed prior to the scheduled time. A phone number will also be given for providing notification for either cancellation or rescheduling.

- **Office Visits / Consultations — 1 Business Day — $50**
- **Aesthetic Treatments (Non-Fraxel) — 1 Business Day — $50**
- **Fraxel Laser Treatments — 2 Business Days — $150**

Patients FAILING TO PAY the above fee will not be allowed to schedule future appointments and will be sent to collections. Multiple Reschedules, Cancellations, or No Shows may result in dismissal from our practice.

****To Cancel or Reschedule Clinic Appointments, please call (505) 954-4422, EXT. 101****

Signed:____ Date:_______________________________

(Copy to Patient Upon Request)

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 forms before seeing a skin care provider.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
We accept cash, check, Visa, American Express, Discover, Mastercard & Care Credit.

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 obtain benefits for covered services. If you have insurance with a company for which we are not providers, we will give you properly completed "super bills" so that you can file your own insurance claims 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. We provide Botox for cosmetic purposes only, which is NOT covered by insurance.

Insurance: This is a contact 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. In the event that you receive a statement with a balance due after insurance adjustments, you are responsible for timely payment on your account.

Balance due terms: Your signature below indicates your agreement with our terms for any unpaid balance due. Any unpaid balances to customer accounts are subject to being sent to a collection agency after repeated statements are sent to the address provided by the patient. 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.

Notice: 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 in writing 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 health 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.

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:

Office Manager
Santa Ana Skin Care Clinic, PC
2205 Miguel Chavez
Suite E
Santa Fe, NM 87505

(505) 954-4422

Responsible party signature:____ Date:________________