

REFINE

A E S T H E T I C S

PATIENT INFORMATION

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Phone Number: _____

Driver's License #: _____ Last 4 SSN: _____ Sex: ☐ Male ☐ Female

Employer: _____ Occupation: _____

How did you hear about us? _____

Do you authorize email communication: Appointment reminders? ☐ Yes ☐ No Specials, Events, etc.? ☐ Yes ☐ No

Race: ☐ White ☐ Black or African American ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander

☐ Asian ☐ Other: _____ ☐ Decline

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Decline Preferred Language: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: _____

GUARANTOR

☐ Check here if the patient is responsible for charges. If someone other than patient, please provide information:

Guarantor Name: _____ Date of Birth: _____ Last 4 SSN: _____

Phone Number: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____

PHARMACY

****We prefer to automatically use Symphony Pharmacy for all prescriptions because of our relationship with them for the benefit of our patients.**

Patient Name: _____

Patient Signature: _____ Date: _____

REFINE

A E S T H E T I C S

GENERAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Are you allergic to ANY medications? ☐ No ☐ Yes: _____

Have you ever had dental anesthesia (Novocaine)? ☐ No ☐ Yes If Yes, any reaction? _____

When taking antibiotics, do you experience: Nausea, vomiting or diarrhea? ☐ No ☐ Yes Yeast Infection? ☐ No ☐ Yes

Current Medications (include prescriptions, over-the-counter, vitamins, and herbals): _____

PATIENT MEDICAL HISTORY

Have you ever been exposed to Hepatitis? ☐ No ☐ Yes

Do you have HIV/AIDS? ☐ No ☐ Yes

Do you have now, or have you ever had diseases or conditions of (please circle): ☐ NONE

Skin Cancer

High Blood Pressure

Irregular Heartbeat

Problem's w/Healing

Dizzy Spells

Pacemaker

Keloids after surgery

Eye Disease/Glaucoma

Blood Clots

Skin Rash

Thyroid Problems

Arthritis/Joint Deformity

Bleeding Problems

Asthma/Wheezing

Convulsions/Epilepsy/Seizures

Swelling Hands/Feet

Chest Pain

Fainting

Diabetes

Heart Attack

Skin Disease

If circled any of the above, please explain: _____

List any other disease or condition: _____

Surgeries in the past 6 months: _____

SOCIAL HISTORY

Do you smoke? ☐ Never ☐ Former ☐ Current, how much: _____

Do you drink alcohol? ☐ No ☐ Yes, how much: _____

FAMILY MEDICAL HISTORY

Skin Cancer ☐ No ☐ Yes, who & type: _____

Other Medical Problems ☐ No ☐ Yes, who & type: _____

FEMALE PATIENTS ONLY

Currently Pregnant? ☐ No ☐ Yes

Trying to conceive? ☐ No ☐ Yes

Breastfeeding? ☐ No ☐ Yes

Using contraceptives? ☐ No ☐ Yes, type: _____

Patient Name: _____

Patient Signature: _____ Date: _____

REFINE

A E S T H E T I C S

ACKNOWLEDGEMENT OF OFFICE POLICIES

A Peaceful Environment

- Your visit to our office should be a peaceful break in your day, and we ask that you help maintain the peace by placing your cell phone on silent or airplane mode while in our office.
- Proof of identity: Refine Aesthetics requires proof of identity on file. We do ask that you provide a photo ID such as a driver's license at check-in. This will be scanned into your private medical record.

How we Communicate with You

- We use your email address & your cell phone number to communicate with you. We email and/or text reminders about upcoming appointments or notifications of events or special offers.
- In return, you can text us with questions, concerns, or even text a picture of your treatment area. This text should not be used for emergency situations. In the event of an emergency, please call 911. Please call us at 512-375-3386
Our NEW text number is: 844-649-0590. Our email Info@RefineAesthetics.com
- You can reach us by phone, text or email. To discuss medical concerns, we do ask that you call or schedule an appointment.
- We provide appointment reminders via email and text 24 hours, 2 days, & 7 days prior to your appointment. Please note, if you opt not to provide contact information, or if you opt out, managing your appointments and adhering to our cancellation policy is your responsibility.

Financial Policies

- Flexible Payment Options: We accept cash, check, and all major credit cards. Payment is due at the time of service. We accept Cherry Payments as a form of payment, Cherry can be set up prior to visit or at the visit. Patient is responsible for signing up.
- Secure Pay Now: We require patients to store a credit card on file with us. This information is stored via our secured merchant services provider Patient Now. We can only store one card on file per client.
- **Missed Appointments / Late Cancellations:** We reserve a space in our schedule specifically for you. If you do not show for your appointment and do not notify us, or if you cancel your appointment with less than a 24-hour notice, you will be responsible for a non-attendance fee of \$100 for every 30 minutes booked. If your appointment is booked for longer than 30 minutes, the fee will increase by \$100 for every additional 30 minutes booked. (1 hour appt is a \$200 fee) If you have a balance of an unpaid No-Show/Late Cancel Fee you will be required to pay this balance prior to scheduling your next treatment/appointment.
- **Prepaid services:** Must be used within 1 year of purchase. Unused services will not be refunded. Cannot be traded for other services/products.
- Promotions: Unless specifically stated, our promotions and/or special pricing may not be combined with other promotional offers. Please present any promotions/special pricing at the time of service; No price adjustments.
- Quoted Prices: We will honor the pricing on a quote through the expiration date on that quote. Otherwise, our prices are subject to change at any time without notice.
- Refunds: Unopened product may be returned within 7 days of purchase. Opened product causing an allergic reaction may be exchanged within 30 days of purchase. A Gift Card or Refine credit will be provided for any products returned. We do not offer refunds on services and treatments.
- Returned Checks: personal checks returned for non-sufficient funds will be charged a fee of \$25.

You Must Participate for the Best Outcomes

- *Follow our Pre-Treatment and Post-Treatment Instructions: We've developed these recommendations so that you will have the best outcome possible.*
- *Treatment Outcomes Vary: Our goal is to give you, prior to receiving treatment, all the information you need to make an informed decision. Aesthetic medicine is not an exact science and your body may react in unexpected ways. We will provide you the very best care, always keeping your aesthetic goals in mind. If you have a treatment outcome that is not what you expected, please make an appointment to come in and discuss your options.*

Patient Name: _____

Patient Signature: _____ Date: _____

REFINE

A E S T H E T I C S

HIPPA INFORMATION AND CONSENT

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

COMMUNICATION BY EMAIL AND TEXT CONSENT

It may become useful during the course of treatment to communicate by email, text message (e.g., "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Refine Aesthetics there is a reasonable chance that a third party may be able to intercept those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION

BY NON-SECURE MEANS: I consent to allow Refine Aesthetics to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Appointment Reminders
- Health Related Information
- Marketing offers

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that message & data rates may apply. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Patient Name: _____

Patient Signature: _____ Date: _____