DermOne™

6752 Rock Spring Road Suite 200
Wilmington, NC 28405

(910) 762-1070 (phone)
(910) 762-1083 (fax)
www.WilmingtonFace.com

Patient Information Form

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Gender: _____ SSN: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

☐ TV
☐ Radio
☐ Google
☐ Other: _____
☐ Patient Referral: _____
☐ Friend: _____
☐ Dr. Referral: _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Section I: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
   Previous smoker? ☐ No ☐ Yes, quit date? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

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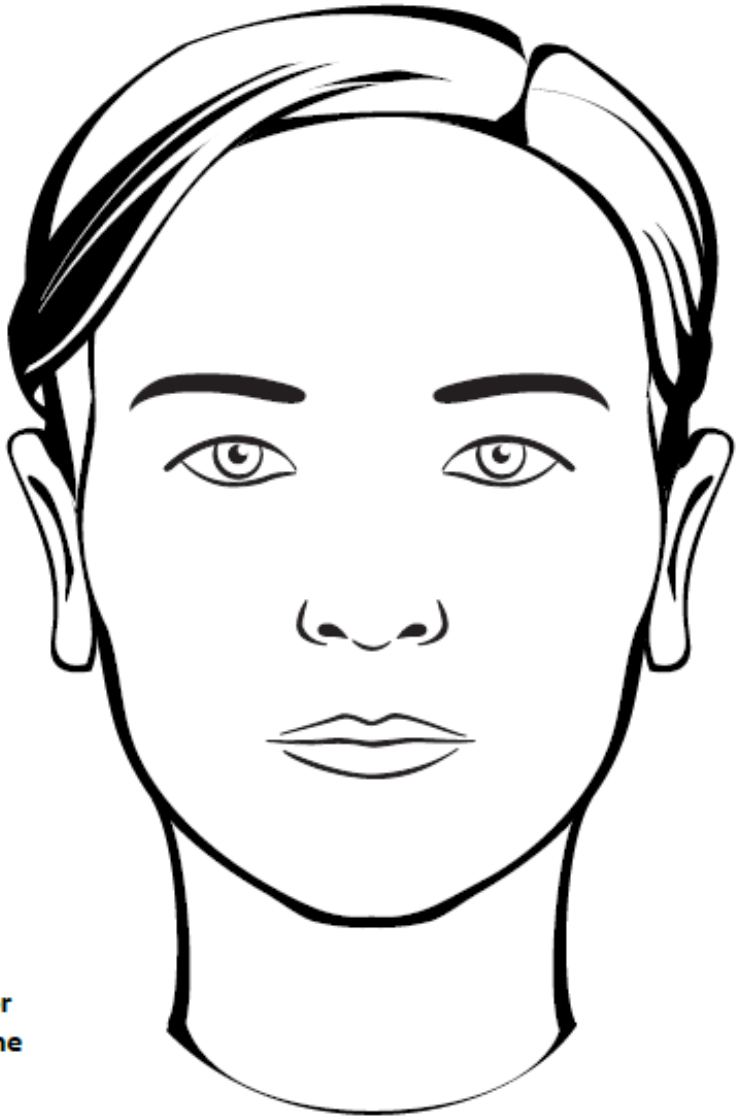
In order to best understand your concerns and help you reach your aesthetic goals, please review the following and rate all the areas that concern you.

Rate each area of concern in the corresponding box on a scale of 1-5.
1 being least bothersome 5 being most bothersome.

Please feel free to indicate any other concerns that you may have that are not shown below.

- ☐ **Frown lines**
- ☐ **Crow's feet**
- ☐ **Dark circles**
- ☐ **Nose** (tip and/or bridge)
- ☐ **Nasolabial folds** (Nose-to-mouth lines)
- ☐ **Oral commisures** (Corner-of-the mouth lines)
- ☐ **Marionette lines** (Mouth-to-chin lines)
- ☐ **Larger pores, poor skin texture, & fine lines**



- ☐ **Forehead**
- ☐ **Freckles and pigmentation**
- ☐ **Blood vessels**
- ☐ **Ears**
- ☐ **Scarring**
- ☐ **Vertical lip lines** (Smokers' lines)
- ☐ **Jowls**
- ☐ **Lips: Definition and/or Fullness**
- ☐ **Neck**
- ☐ **Other:**_____
  _____

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Section II: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section III: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you or do you still have:	YES	NO	Description
2. Asthma	☐	☐	
3. Emphysema	☐	☐	
4. High Blood Pressure	☐	☐	
5. Heart Trouble	☐	☐	
6. Hepatitis or Liver Trouble	☐	☐	
7. Kidney Trouble	☐	☐	
8. Diabetes	☐	☐	
9. Epilepsy or Seizures	☐	☐	
10. Stroke	☐	☐	
11. Problem Scarring	☐	☐	
12. Have you been advised to or had psychiatric care?	☐	☐	

13. Others Not Listed: _____

Section IV: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

_____

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Section V: Allergies and Sensitivities

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

Do you have a known latex allergy? ☐**No** ☐**Yes**

Section VI: Family History

	Have any blood relatives had any of the following?	YES	NO	Description
1.	Cancer	☐	☐	
2.	Bleeding Tendency	☐	☐	
3.	Leukemia	☐	☐	
4.	Heart Disease	☐	☐	
5.	High Blood Pressure	☐	☐	
6.	Repeated Infections	☐	☐	
7.	Chronic Lung Disease	☐	☐	
8.	Tuberculosis	☐	☐	
9.	Asthma	☐	☐	
10.	Severe Allergies	☐	☐	
11.	Kidney Disease	☐	☐	
12.	Arthritis	☐	☐	
13.	Mental Illness	☐	☐	
14.	Convulsions or Fits	☐	☐	
15.	Migraine Headaches	☐	☐	
16.	Diabetes	☐	☐	
17.	Gout	☐	☐	
18.	Thyroid Trouble	☐	☐	
19.	Obesity	☐	☐	

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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Consent to Communicate

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message – if so, list cell carrier:			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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HIPAA Information and Consent Form

Patient Name:

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 the both the practice and the patient.

9. 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.

Signature: _____ Date: _____

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Patient Financial Policy

We consider it a privilege that you have chosen us for your aesthetic rejuvenation and reconstructive goals. We strongly believe that an informed patient is a good patient and that your clear understanding of our Patient Financial Policy is important to our professional relationship. Therefore, we strive to inform you of all the medical aspects of your needs and also would like to advise you on our financial policy for both cosmetic and reconstructive surgery procedures.

Cosmetic Surgery / Major Procedures

- Our cosmetic consultation fee is complimentary. However, non-emergency cancellations require a 24 hour notice. If the session is not cancelled within 24 hours a $35 no show fee will be charged for all missed consultations. A detailed quote for the proposed surgery will be provided after your in-office consultation. The quoted fee will include all of the pre and postoperative visits. The quoted surgical fee does not include any preoperative services you may require, such as x-rays, blood tests, pre and postoperative medications, labs or evaluation by another physician or specialist before undergoing the surgical procedure.

- To schedule and hold a cosmetic surgery date a non-refundable $500 deposit is required. This amount will be deducted from the total surgery fee. Payment for the remaining balance of the surgery fee is due at the preoperative exam or two weeks prior to the operation.

- If the surgery is rescheduled within two weeks of your surgery date, there will be an additional non-refundable $500 rescheduling fee. If the surgery is rescheduled less than seven days of your surgery date you will forfeit your full surgery deposit. This is done to maintain the continuity of a very valuable and busy schedule. We reserve a considerable amount of discretion in implementing this policy.

- Plastic surgery is an art and occasionally revisions will be necessary. These will always be within one year of the original procedure date. The majority of the time, no surgeon fees will be charged, however facility and anesthesia fees will apply for the procedure. Dr. Deidra Blanks reserves the right to determine a revision versus a separate procedure that is being requested.

- Due to product costs and product preparation, Sculptra treatments require a nonrefundable $500 per vial deposit to schedule an appointment. An appointment can be moved and deposit applied to a different date of service if the patient notifies the practice at a minimum of 48 hour before their scheduled treatment.

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- We do not have in-office payment plans. We offer our patients the option to secure financing through CareCredit®. The CareCredit Card is just as easy to use as a regular credit card and is North America's leading patient payment program. www.carecredit.com.

- Consultations for aesthetic services including skin care and makeup are complimentary. There are no refunds on skin care products or services.

Reconstructive Surgery Procedures

We are committed to providing you with the best care possible. Reconstructive consultation fees will be billed to your insurance company. It is our patient's responsibility to provide our office with current insurance information. We will ask for your insurance card at your first visit to obtain a copy for our records. We will occasionally request a copy at a later date to update your records so please have your insurance card every time you come to the office. If current information is not obtained at the time of service, it will become the patient's responsibility to pay until current information is provided to the clinic.

- We are in network with United Healthcare, CIGNA, Blue Cross Blue Shield, Humana, Tricare, Medicare, and Medicaid.

- As a courtesy, we will file your claims for any reasonable insurance coverage with your primary and secondary insurance carriers. We cannot ethically, and will not, fill out any forms in such a way as to disguise the true purpose of any cosmetic procedures you wish to have done. Furthermore, even in cases that are clearly functional or reconstructive, in Dr. Blanks' opinion, we cannot guarantee that your particular insurance company will agree with Dr. Blanks' finding and cover your procedure.

- If your insurance company declines any of the fees associates with our services to you, even those billed as medically necessary but which are declined by your insurer as being cosmetic, medically unnecessary or an uncovered preexisting condition, you, the patient, are ultimately responsible for all charges incurred. You should consult the terms of your own benefit plan to determine if there are any exclusions or other benefit limitations applicable to the procedure of interest. In the manner, you can ensure all necessary requirements for coverage are known and met.

- We will not become involved in disputes between you and your insurance carrier. We will supply all necessary information to assist you. Please remember that insurance is a contract between you, the patient, and your insurance company.

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Ultimately you are responsible for payment in full to Wilmington Aesthetic Facial Plastic Surgery.

- Some reconstructive procedures require pre-authorization from your insurance carrier. Our office is pleased to provide this service following your consultation. The authorization process may take 4 to 6 weeks. Surgery will not be scheduled until the authorization is received.
- Co-payments and deductibles are due at the time you see the doctor.
- When your insurance company has paid their portion of the charge, a statement will be generated and mailed to you. Any balance due is your responsibility and is due upon receipt of the statement from our office.
- Patients being seen as a result of work-related injuries are still responsible for charges incurred at the time of service. Please notify our office if you have such a claim so that prior to the time of your visit we may verify coverage of your charges by your employer if not already done at the time of making the initial appointment. We will make every effort to collect your charges from your employer or their worker's comp insurance carrier, but if we cannot verify coverage, you will be responsible for payment of your charges. Also, if your employer does not remit payment for your charges within a reasonable period of time, we will have no choice but to bill you directly.
- We accept cash, Care Credit and the following major credit cards: Visa, Discover, Mastercard, and AMEX
- We charge a $35 service fee for all returned checks (surgeries only).
- Should our billing office fail to collect the balance on a patient's account, we must then place the account with our attorney collections. Should that occur, an administrative fee will be added to your account balance.

Date: _____

Signature:_____