Patient Information

(Please Print)

Patient's Name: _____
Last First Middle

Birthdate: ___ /___ /___ SSN: _____ Gender: ☐Male ☐Female

Race: _____ Ethnicity: _____ Preferred Language: _____

Marital Status: ☐ Single ☐ Married ☐ Other: _____ Spouse's Name: _____

Home Address: _____
Street & Apt # City State Zip

Home Phone: _____ Cell Phone: _____Work Phone: _____

Where do you prefer to be contacted? _____ May we leave a message? ☐ YES ☐ NO

E-mail: _____ **May we send communications by e-mail?** ☐ YES ☐ NO

Employment Information

Occupation: _____ Employer: _____

Address: _____
Street City State Zip

Phone #: _____ Ext. _____ **May we leave a message?** ☐ YES ☐ NO

If Under the Age of 18

Name of Parent/Legal Guardian: _____

Relationship to Patient: _____

Who may authorize treatment for the minor? _____

Emergency Contact

Name: _____ Relationship: _____

Home Phone: ( ) _____Work: ( ) _____ Cell: ( ) _____

Home Address: _____
Street & Apt # City State Zip

How did you hear about Dr. Coley?

☐ Family/Friend: _____ ☐ Physician: _____ ☐ Seminar/Event

☐ Billboard ☐ Internet (website, Google) ☐ Other: _____

Insurance Information

Primary Health Insurance: _____ Policy #:_____ Group #: _____

Insurance Referral Required? ☐ YES ☐ NO Copay? _____ Employer: _____

Insured Name: _____ Birthdate: ___ /___ /___ SSN: _____

Secondary Health Insurance: _____ Policy #:_____ Group #: _____

Insurance Referral Required? ☐ YES ☐ NO Copay? _____ Employer: _____

Insured Name: _____ Birthdate: ___ /___ /___ SSN: _____

I understand that office visit charges are payable on the day service is rendered. I authorize Coley Cosmetic and Hand Surgery Center to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Coley Cosmetic and Hand Surgery Center and myself.

Patient Signature: _____ Date: _____

Cosmetic Interest Questionnaire

Patient's Name: _____ Birthdate: ___ /___ /___

What brings you to the office today?

_____

_____

Would you like to receive a complimentary consultation from our Aesthetician today?

☐ YES ☐ NO

What are your areas of concern?

(Please check all that apply)

FACE	*BREASTS*	*BODY*
☐ Frown lines between the brows	☐ Size	☐ Abdomen
☐ Skin Quality	☐ Shape	☐ Legs
☐ Hyper/Hypo-pigmentation	☐ Symmetry	☐ Arms
☐ Loose skin		☐ Hips
☐ Neck – Double chin		☐ Back
☐ Ears		☐ Buttocks
☐ Eyelids or Brows		
☐ Lips		
☐ Other		

Are you interested in learning more about the following?

(Please check all that apply)

☐ Botox or Dysport
☐ Injectable Fillers: Juvederm, Radiesse, Sculptra, Restylane
☐ Facial Cosmetic Surgery (Eyes, Brows, Nose, Chin, Face Lift)
☐ Liposuction
☐ Tummy Tuck
☐ Breast Surgery
☐ CoolSculpting
☐ Chemical Peels
☐ Skin Care Products
☐ Laser Hair Removal
☐ Tattoo Removal

Other: _____

_____

MEDICAL HISTORY

Patient Name: _____DOB: _____ Height_____ Weight:_____
Reason for Visit: _____ Referred by: _____

MEDICAL HISTORY: (Circle all that apply. Please provide a brief explanation to any "YES" answers)

Ear/Eye (dryness)/Sinus problems/nose bleeds	YES	NO	Liver problems/Hepatitis	YES	NO
Heart Disease/Surgery	YES	NO	GI problems (ulcer/reflux/abdominal pain)	YES	NO
High or Low Blood Pressure	YES	NO	Genitourinary Problems (UTI/kidney or bladder issues)	YES	NO
CAD/chest pain/palpitations	YES	NO	Arthritis/Joint pain	YES	NO
Bleeding Disorders/Anemia/Bleeding Tendencies related to anticoagulant therapy/DVT or PE/bruises easily	YES	NO	Anxiety/Depression	YES	NO
Pulmonary Disease/Sleep Apnea/cough/ Asthma	YES	NO	Stroke/Seizures/paralysis/Migraines/dizziness	YES	NO
Thyroid problems	YES	NO	Cancer	YES	NO
Diabetes	YES	NO	Infections (including MRSA)/STD's	YES	NO

OTHER MEDICAL PROBLEMS:

_____

_____

MEDICATIONS: (include prescription, over the counter, vitamin and herbal remedies)

_____

_____

_____

ALLERGIES and REACTIONS: (include all medication, food, tape and latex allergies)

_____

HOSPITALIZATIONS/SURGICAL HISTORY: (include any reactions to anesthesia or experiences with post-operative nausea)

_____

_____

FAMILY ILLNESSES: (include any reactions with anesthesia)

_____

_____

SOCIAL HISTORY:

Do you smoke? ☐ YES ☐ NO If so, how much per day? _____ How many years? _____
Do you consume alcohol? ☐ YES ☐ NO If so, how much per week? _____
Do you use any recreational drugs? ☐ YES ☐ NO If so, how much? _____ How often? _____

WOMEN ONLY:

Are you or could you be pregnant? ☐ YES ☐ NO
Total number of pregnancies: _____ Total number of live births: _____ Did you breastfeed? ☐ YES ☐ NO
Do you have a family history of breast cancer? ☐ YES ☐ NO
Have you had a mammogram? ☐ YES ☐ NO If so, when? _____ What were the results? _____

PHARMACY INFORMATION:

Pharmacy Name and Location: _____ Phone # _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient/Parent Signature_____ Date_____

Financial Policy

We are delighted that you have chosen our facility as a provider in your cosmetic surgical and non-surgical needs. Our goal is to provide you with useful information about our financial policy to ensure that you have the best experience possible. If you have any questions regarding this policy, please contact our Clerical Office Specialist or our Office Manager at (336) 617-8645.

Initial Visit

On your initial visit, you will be asked to provide demographic information. Following that visit, periodic updates may be requested. If, during the time you are a patient at our practice, you change any of your personal information, including address, telephone number, and email address, please inform us.

Self-Pay Accounts

Self-pay accounts are patients who are having procedures that have been deemed "cosmetic" (considered "not medically necessary"). Self-pay patients are required to pay $50.00 at their initial visit or consultation. **NOTE:** Cosmetic consultation fees are NON-REFUNDABLE. However, if you choose to schedule a procedure, service or purchase a product ON THE SAME DAY as your consultation, the consultation fee will be applied to the cost of your procedure, service or product.

Fees, Outstanding Balances and Payments

Prescriptions are not included in the cost of your cosmetic procedure. Initial pre-surgical testing (includes CBC without differential and BMP) are included in the cost of your cosmetic procedure. For the safety and well-being of our patients, Dr. Coley reserves the right to require additional pre-surgical testing. You are responsible for any medical bills arising from testing radiology, pathology, supplies or other services provided or recommended by Dr. Coley. Payment in full is required at the time of your visit. We accept cash, certified or cashier's checks, Visa, MasterCard, American Express or Discover. Financing is also available through Care Credit. For more information regarding this program, please speak to a member of our staff. Personal Checks will not be accepted as a form of payment towards cosmetic surgery, products or for any other cosmetic services. Checks returned for insufficient funds will be charged a service fee of $35.00, in addition to the original amount of the check and will be placed on a "cash only" basis.

Disability Forms, FMLA and Other Forms

These forms take a considerable amount of time for our staff to complete. We ask that you allow 7-10 business days for completion of these forms. There will be a charge of $25.00 due at the time the forms are received. There will be an additional fee for requests to expedite completion of these forms. Under no circumstances, can forms be completed in less than five (5) business days.

Medical Records

Patients are required to complete and sign a written consent prior to release of their medical records. According to North Carolina's Statute 90-411, patients will be charged a handling fee of $10.00 and copying charges of 75 cents/page for pages 1-25, 50 cents/page for pages 26-100 and 25 cents/page for pages in excess of 100. Payment is due in advance and we ask that you allow 7-10 business days for processing. Collaborating physicians and specialists assisting in the care of a patient will not be charged for copies of medical records.

Refunds

Refunds are not permitted on purchases made toward skincare products. If you are not completely satisfied, you may return your skincare with 7 days of the original purchase date. Our aesthetician will be happy to discuss replacement products OR issue you a credit on your account that may be used on future purchases.

Cosmetic Surgery Scheduling

Patients scheduling cosmetic procedures are required to pay a NON-REFUNDABLE surgery deposit BEFORE scheduling their procedure. The surgery deposit is equivalent to 10% of the total quoted procedure cost. The surgery deposit will be applied to the total quoted procedure cost leaving a remaining balance that must be paid 14 days BEFORE their scheduled procedure. If the balance is not paid within 14 days of the scheduled procedure, the surgery may be cancelled or postponed.

Cosmetic Surgery Cancellation

For the safety and well-being of our patients, Dr. Coley reserves the right to cancel or reschedule a cosmetic procedure, if he deems it to be medically necessary.

Patients cancelling their cosmetic procedure 4 weeks or more before their scheduled procedure will receive a full refund of their surgery deposit, less $50.00 for processing and administrative fees. Patients cancelling their cosmetic procedure less than 2 weeks before their scheduled procedure will not receive a refund of their surgery deposit. A credit will be issued for those patients who cancel their cosmetic procedure between 2 and 4 weeks before their scheduled procedure, which can be applied toward the cost of a future surgery, products or other cosmetic services. After 6 months, this credit will forfeited to the practice. **NOTE:** We understand emergencies or other extenuating circumstances may arise that may cause need for a patient to cancel their cosmetic procedure. Dr. Coley and his Office Manager will evaluate the circumstance on a case by case basis to determine the proper course of action.

My signature below indicates that I understand and agree to the above policy.

Patient Signature: _____ Date: _____

HIPAA AUTHORIZATION CONSENT FORM

Patient's Name: _____ Birthdate: ___ /___ /___

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you for treatment, payment or healthcare operations.

I understand that as part of my care, Coley Cosmetic & Hand Surgery Center originates and maintains paper and/or electronic medical records containing my health information. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify services billed were provided, and
- A tool for routine healthcare such as assessing quality and reviewing the competence of healthcare professionals

We take our patients' privacy very seriously and will not disclose any information without your consent.

Do you give permission for our office to discuss your health history or any medical concerns with anyone other than yourself?

( ) YES ( ) NO

If yes, please list the individual(s) and their relationship to you.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Should it become necessary to disclose my protected information to another entity for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax and transcription. My signature acknowledges that I was presented a copy of Patient's Rights and Responsibilities and Privacy Practices from Coley Cosmetic & Hand Surgery Center, PA. I am aware that a copy of this signed consent will remain on file and that it is my responsibility to inform Coley Cosmetic & Hand Surgery Center, PA of any needed changes to this consent.

Patient Signature: _____ Date: _____