skin · science · soul
Medical Aesthetics

PERSONAL HISTORY QUESTIONNAIRE

This information is confidential and will not be released without your authorization.

Date _____

Name _____ DOB _____ Age____ Height_____ Weight_____
Last First Middle
Email: _____ Address_____ Phone: _____
Primary Doctor_____ Referring Doctor (if any) _____
Areas of Concern/Interest for consultation - Interest:
_____

PAST MEDICAL HISTORY: (If yes, give date of occurrence.)

Anemia Y N _____ Asthma Y N _____ Arthritis Y N _____ Anxiety Y N _____ Bronchitis Y N _____
Bleeding Probs Y N _____ Blood clots in legs/lungs Y N _____Cancer Y N _____ Depression Y N _____
Diabetes Y N _____ Glaucoma Y N _____ Hepatitis/Liver Y N _____ HIV Y N _____
High Blood Pressure Y N _____ MRSA/Staph Y N _____ Seizures Y N _____ Sleep Apnea Y N _____
Stroke Y N _____ Thyroid Y N _____ Ulcers Y N _____ Allergies Y N _____ Other: _____
Do you regularly smoke? Y N How much per day _____
Do you regularly drink over 3 cups of coffee per day? Y N
Do you regularly drink alcohol or beer? Y N How much? _____

MEDICATIONS: What medications are you presently taking? Write name, dosage.

_____
_____
_____
_____

Do you take herbal supplements? Y N If yes, what are they? _____

DRUG OR SUBSTANCES TO WHICH YOU ARE ALLERGIC _____
What happens when you take this?_____

FAMILY HISTORY: Have blood relatives had? (Please circle and give relation.)

High blood pressure_____ Arthritis_____ Asthma _____
Diabetes _____ Stroke_____ Goiter_____
Bleeding disorders _____ Breast cancer _____ Other cancer _____

SERIOUS ILLNESSES OR INJURIES: Please list any serious illnesses or Injuries and dates.

Illness/Injury_____ Year_____ Illness/Injury _____Year_____
Illness/Injury_____ Year _____ Illness/Injury _____ Year _____

OPERATIONS: Please list operations and year.

Operation_____ Year _____ Operation_____ Year_____
Operation_____ Year _____ Operation_____ Year_____

WOMEN ONLY

Is there a chance you may be pregnant? Y N Regular menses? Y N Date of last menstrual period_____
How many pregnancies? _____ How many children? _____ Did you breastfeed? Y N How long? _____
Date of last mammogram _____ ❑Normal ❑ Abnormal
Specify abnormality_____ Breast cancer: L R Date_____

ARE THERE ANY OTHER TREATMENTS YOU ARE INTERESTED IN OR ISSUES YOU WOULD LIKE TO TALK WITH YOU ABOUT? (Circle)

General Skincare/ Help Choosing Products Best for You Botox Fillers Acne/Acne Scars Aging Skin Sagging Skin
Area Under Chin Brown Spots Red, Irritated Skin Laser Hair Removal Hair Restoration Sweating Scar Treatment
Weight Management DNA Analysis BioIdentical Hormones Intimate Rejuvenation Incontinence EMSCULPT Cellulite

FINANCIAL POLICY

Thank you for choosing us! We are committed to your successful treatment. We require that you read and sign prior to treatment. We will make every effort to avoid a misunderstanding.

METHODS OF PAYMENT This office will accept the following methods of payment for services rendered: **Visa/MC/AmEx/Cash/Cashier's Check/Personal Checks.** We offer **Prosper Healthcare Lending** and other medical loan payment plans to help with the cost of your treatment. We may offer in-house payment plans and Layaway Plan as well. Please refer to the specific program policy or the surgery financial policy for more detail.

REGARDING INSURANCE

Skin Science Soul does not file insurance and are not providers for any insurance company. Responsible parties with Insurance coverage may choose to file insurance on their own: however, payment in full must still be rendered to us before the procedure is performed. The most common misconception concerning insurance is that your policy will cover the total cost of surgical fees charged. Your surgical treatment is not dictated by what your insurance will cover. Together, Dr. Sholar and you create your treatment plan based on what your current medical needs are. We cannot limit your care to just what is covered by your insurance plan. You, as the patient, are ultimately responsible for the full amount of the procedure and surgical costs.

FINANCIAL RESPONSIBILITY

Accounts in post due for 90 days will be submitted for collection, referred to necessary legal authorities and credit bureau, and may result in court action if prior arrangements to pay have not been made or if you tall to make your agreed upon installment payments.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing be best treatment possible for patients and we charge what we believe is appropriate, usual and customary for the area. You are responsible for payment in full regardless of any insurance company's determination of the usual and customary rates for similar procedures and treatment. We do not accept reasonable and customary charge calculations by other outside parties.

REQUEST FOR MEDICAL RECORDS

Requests for medical records will be honored in a timely manner as required by applicable law. All requests should be made at least 72 hours in advance of date needed. Additionally, a charge for copying and malting medical records may be assessed per and only to the extent allowed by applicable laws. Should your attorney request medical records on your behalf, one invoice will be sent to the attorney for payment, however the bill is the responsibility of the patient regardless of who requested the records on the patient's behalf. Records will not be released without appropriate documentation of authorization of release.

RETURNED CHECK FEE

We charge a returned check fee of $40 per check. If you are notified by our office that your check was returned, we will afford you a limited opportunity to replace the returned check with cash or a bank cashier's check in the amount outstanding plus the service fee. Please note that persons who knowingly write bad checks may be prosecuted for fraud in the State of Texas. Patients acknowledge that they are responsible for any and all collections costs, service fees, and court costs associated with the collection of outstanding balances on their account.

CREDIT CARD & FINANCING AGREEMENTS (Please Initial_____)

Once you have charged a treatment. product, or procedure to your credit card or to a financing company, and you subsequently cancel your services with us, you will not be issued a refund under any circumstances, but will be issued an in-house credit for future services only. You may also be subject to credit card processor fees.

LATE CANCELLATION/NO SHOW FEE POLICY (Please Initial_____)

Please provide us with at least 24 hours advance notice for any appointment changes. This will enable us to better accommodate another patient. To assure scheduling efficiency, patients who fail to call within 24 hours of the appointment will be billed a cancellation fee. **There is a $50 no show/cancellation fee for office visits/consults for each provider. Should you miss or make a late cancellation for any procedures or medspa services scheduled, you will be billed for 50% of the cost of the procedure.** If you have an emergency, we will evaluate a waiver of these fees on a case-by-case basis. Although we will do our best to do courtesy reminder emails, texts, or calls for consultations, procedures, and spa services, It is the patient's responsibility to remember the day and time of their appointment. Payment of the NO-SHOW FEE will be made automatically via the credit card provided at the time of appointment scheduling. If that, fails, however, payment must be made in cash, valid credit card, or verified check before further appointments are allowed.

You agree to pay all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%. **(Please Initial_____)** ❑ I acknowledge that I have read and understand the foregoing Financial Policy ❑ I agree to this policy as a condition of receiving services or treatment ❑ I realize I am responsible to pay any and at charges agreed upon ❑ I further authorize the release of pertinent medical information for all purposes necessary and appropriate for the submission and payment of claims for and on behalf of my account with Skin Science Soul.

I, (please print) _____ have read and agree to the above financial policies. I understand it is my responsibility to pay any fees to this office. Signature_____ Date _____

Text and Email Consent

We now can email and/or text you, reminding you of your appointments. If you would like to receive this feature in the future, please read the consent below and sign.

Consent to Email and/or Text Message for Appointment Reminders and Other Clinic Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general Spa reminders/information.

- I consent to receiving appointment reminders and other communications/information at that email and/or text from Skin Science Soul. (Patient initials) _____
- I consent to receive text messages from the Skin Science Soul at my cell phone and any number forwarded or transferred to that number. The **cell phone number** that I authorize to receive text messages for appointment reminders, feedback, and general spa reminders/information is (____)_____ Carrier: _____ (Patient initials) ____
- The **email** that I authorize to receive email messages for appointment reminders and general reminders/feedback/information:_____

I understand that this request to receive emails and/or text messages will apply to all future appointment reminders, feedback, and other information unless I request a change in writing.

Patient Signature:_____ Date:_____