INTEGRATED AESTHETICS

PLASTIC SURGERY • DERMATOLOGY • MED SPA

Welcome to our practice!

What is the main reason for your upcoming consultation? _____

_____

How long have you been considering this procedure? ☐ Days ☐ Months ☐ Years

What is your price range? _____ Are you interested in financing options? ☐ YES ■ NO

AESTHETIC GOALS

Although you may identify with multiple statements below,
please select the box you relate to the most.

■	I want to look like me, not fake or "done." I want subtle, natural-looking results. I don't want to look like I'm 20. I just want to take a few years off.
☐	It's important for me to look my best for my job. I connect my appearance to my social status. I'm worried signs of aging may impact me professionally and socially.
☐	My friends have received injectable treatments, and I'm curious about getting these treatments myself. I have a specific treatment/ look in mind.
☐	I'm bothered by an aspect of my appearance. I have a facial concern I'd like to fix. I feel self-conscious around other people because of my appearance.

On a scale of 1-5, which is the most appropriate number?

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age. ☐

YOUNGER THAN		TRUE AGE		OLDER THAN
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles. ☐

YOUNGER THAN		TRUE AGE		OLDER THAN
1	2	3	4	5

5061 FM 2920 Spring, Texas 77388 | www.myintegratedaesthetics.com | P | 281.404.5454 F | 281.404.9336

INTEGRATED AESTHETICS

MEDICAL INTAKE FORM

ALL INFORMATION IS STRICTLY CONFIDENTIAL.

MEDICAL HISTORY

Please list any medical conditions and previous surgeries you have had

YEAR DIAGNOSED	CONDITION	TREATMENT, INCLUDING SURGERY

Have you had any adverse reaction to anesthesia or surgical complications? If so, please describe

_____

_____

FEMALE WHAT IS THE LAST DATE OF YOUR MENSTRUAL CYCLE? _____

ARE YOU PREGNANT? ■ NO ☐ YES ARE YOU NURSING? ■ NO ☐ YES

MEDICATIONS/ ALLERGIES

Do you have any medication allergies?

☐ NO ☐ YES, Please list medication and describe reaction

_____

_____

Do you have any food allergies?

☐ NO ☐ YES, Please list food item and describe reaction

_____

_____

Do you take any medications and/or supplements?

☐ NO ☐ YES, Please list with dosage

_____

_____

HEALTH HABITS

Check which substances you use and describe how much you use

☐ Caffeine _____

☐ Drugs _____

☐ Tabacco _____

☐ Other _____

EXERCISE

Do you do the following weekly or more often

☐ YOGA/ PILATES ☐ WEIGHTLIFTING

☐ RUNNING ☐ SWIMMING

☐ OTHER ACTIVITY _____

HEIGHT _____ **WEIGHT** _____

INTEGRATED AESTHETICS

MEDICAL HISTORY

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MEDICAL HISTORY

	NO	YES	DESCRIPTION
SEASONAL ALLERGIES	☐	☐	
AUTO-IMMUNE DISEASE	☐	☐	
ARTHRITIS	☐	☐	
ASTHMA/ COPD	☐	☐	
HEART PROBLEMS	☐	☐	
PACEMAKER/ DEFIBRILATOR	☐	☐	
BLOOD CLOTTING DISORDER	☐	☐	
HIGH/ LOW BLOOD PRESSURE	☐	☐	
CANCER: TYPE?	☐	☐	
DEEP VENOUS THROMBOSIS/ PULMONARY EMBOLISM	☐	☐	
DEPRESSION	☐	☐	
DIABETES	☐	☐	
RENAL DISEASE	☐	☐	
GERD	☐	☐	
HEARING/ VISION LOSS	☐	☐	
HEPATITIS	☐	☐	
HIV/ AIDS	☐	☐	
NEUROMUSCULAR DISORDER	☐	☐	
RADIATION TREATMENT	☐	☐	
SEIZURES	☐	☐	
SEVERE REACTION TO ANESTHESIA	☐	☐	
OTHER	☐	☐	

SIGNATURES

I certify that the above information is correct to the best of my knowledge. I will not hold the staff of Integrated Aesthetics responsible for any errors or omissions that I may have made in the completion of this form. I acknowledge that I have received the Notice of Privacy Practices.

PATIENT NAME _____ DOB _____

SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____

INTEGRATED AESTHETICS

PATIENT INFORMATION FORM

PATIENT NAME _____ DOB _____ AGE _____

SSN _____ EMAIL ADDRESS _____ .COM

PHONE _____ (HOME) _____ (CELL) _____ (CELL PHONE CARRIER)

DRIVERS LICENSE NUMBER _____ SEX _____

(Please give a copy to the front desk for our records)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RACE
- ☐ White
- ☐ Black Or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ American Indian or Alaska Native

ETHNICITY
- ☐ Hispanic or Latino
- ☐ Non-Hispanic
- ☐ Unknown

PREFERRED LANGUAGE _____

EMPLOYER NAME _____ ADDRESS _____

OCCUPATION _____ WORK PHONE _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

_____ PHONE _____

PLEASE LET US KNOW HOW YOU HEARD ABOUT OUR CLINIC?

- ☐ Patient Referral _____
- ☐ Doctor Referral _____
- ☐ Medspa Referral _____
- ☐ Current Dermatology Patient
- ☐ Real Self
- ☐ Facebook
- ☐ Instagram
- ☐ myintegratedaesthetics.com
- ☐ 2920 LED Sign
- ☐ Google Search
- ☐ Billboard

PLEASE EXPLAIN THE REASON FOR YOUR VISIT

_____

EMERGENCY CONTACT NAME _____

RELATIONSHIP ☐ Spouse ☐ Parent/ Guardian ☐ Other _____

PHONE _____ (HOME) _____ (CELL) _____ (WORK)

PHARMACY _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INTEGRATED AESTHETICS

PAYMENT POLICY

Thank you for choosing our office for your plastic surgery, dermatology, and med spa needs. We are Committed to your treatment being successful.

- We accept cash, check, Visa, Mastercard, American Express, and Discover
- We offer and accept carecredit and alpheon financing.

AESTHETIC SERVICES

Since we offer a broad array of services and we customize our treatment plans based on individual needs, we will start with a consultation. During the consultation, we will provide you with a quote for proposed services. Payment is due at the time that services are rendered.

DERMATOLOGY MEDICAL SERVICES

We offer self-pay dermatology services. Payment is due at the time that services are rendered. Medicare patients, please note that Medicare does not reimburse for direct-pay services. For patients who have out-of-network benefits with their commercial insurance plans, we can provide you with a superbill so that you so that you can request full or partial reimbursement from your insurance carrier.

COSMETIC SURGERY

During your consultation, we will provide you with a customized quote, which will include surgeon fees, inventory fees, as well as anesthesia and facility fees. This quote will also outline the details of our payment policy for surgery.

SKIN CARE PRODUCTS

We take pride in our expertise and we want you to be happy with the skin care products that we recommend. We will exchange products within 30 days of original purchase. So, please try your products when you purchase them, and let us know if we need to make an exchange.

CANCELLATION & NO-SHOW POLICY

As a courtesy to the office and other patients who are requesting appointments, please notify us at least one business day before your scheduled appointment if you need to cancel or reschedule. You will be charged $125 if you fail to show for your appointment or if you do not give the office sufficient notice

POLICY REGARDING MINOR PATIENTS

The accompanying a minor and the parents/ guardians are responsible for full payment.

PATIENT NAME _____ DOB _____

SIGNATURE _____ DATE _____

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HIPAA INFORMATION AND CONSENT FORM

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 manger 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.

PATIENT NAME _____ DOB _____

SIGNATURE _____ DATE _____

INTEGRATED AESTHETICS

CONSENT TO COMMUNICATE

OUR COMMUNICATIONS TO YOU

We are pleased to be able to offer text and/or email communications. Please note that these methods are not 100% confidential and you can opt out.

If you prefer not to receive emails pertaining to appointment confirmations, instructions, or promotions please indicate your preference by initialing here_____

If you prefer not to receive texts from us, text "stop" to the practice. To resubscribe, text "start" and we will again be able to text you.

Also, please join us on Facebook and Instagram. We show live procedures, before-and-after pictures and some fun.

A NOTE ABOUT COMMUNICATING WITH US

Please call us anytime. Our phone number **(281) 404-5454**. Our normal business hours are Monday, Tuesday, and Thursdays from 8-5, Wednesdays and Fridays from 9-5, and on Saturdays from 9-3.

In addition to calling, you can now text us. Our texting number is **(281) 305-0358**. Please save this number in your phone under Integrated Aesthetics Text, as this number is only for texting. It can take up to fifteen minutes for us to receive your text. As long as we have your cell number in our system, we will be able to identify you as the sender of the message. We can also receive photos that you text; your photos will be automatically uploaded into your chart in our electronic medical record system. We typically text back throughout the business day.

PATIENT NAME_____ DOB _____

SIGNATURE_____ DATE _____

Submit Form Here | Clear Fields

If you are having trouble submitting, download the file and open in (Adobe Acrobat) as a PDF.
File>Save As Open File in Adobe PDF/Reader/Acrobat Fill out form> Click Submit