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? Circle 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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INTEGRATED AESTHETICS

Authorization for Use and Disclosure of Protected Health Information

AUTHORIZATION

By my signature below, I affirm, as a patient of the Practice named above OR as the parent or legal guardian of a minor child that is a patient of the Practice named above (the "Patient"), that I authorize the Practice: (i) to capture photographic or video images of the Patient (the "Images"); (ii) to reproduce, use, and disclose the Images, with or without the Patient's name; (iii) to publicize the fact that medical services were provided to the Patient; (iv) to reproduce and publish any testimonials the Patient provides regarding the Practice (collectively referred to herein as the "Information"); and (v) to secure copyright registration for any materials that incorporate the Information, at the election and sole expense of the Practice. The authorization is given to the Practice listed above, for disclosures to any persons, without limitation, who may view the Information in printed or digital form in promotional materials including social media or Internet sites.

PURPOSE

The purpose of this authorization is to permit the Information, including Images, to be used for marketing of the Practice, and I explicitly consent to the use of Information for advertising and marketing activities to promote the Practice. I acknowledge and agree that no compensation will be provided for the use of the Information.

EXPIRATION AND REVOCABILITY

If Patient is signing on his or her own behalf, this authorization expires when the Patient informs the Practice that he or she is no longer a patient of the Practice. If Patient is signing on behalf of a minor child, this authorization expires when the Patient reaches the age of majority, but the authorization remains valid for protected health information already used or disclosed until revoked by the Patient who has attained majority. However, I understand that protected health information already used or disclosed prior to any revocation may no longer be protected. I understand that I may revoke this authorization at any time by notifying the Practice by Certified Mail, return receipt requested, but that revocation will only affect uses and disclosures initiated after the date notice is received by the Practice. Upon receipt of the notice of revocation, the Practice will make reasonable efforts to remove protected health information from social media platforms over which it has control, but cannot guarantee removal from all sites. I understand and explicitly acknowledge that the Internet allows for wide sharing and forwarding of information, and that the Practice cannot control all re-disclosure of information.

NO EFFECT ON TREATMENT

This authorization is voluntary. I understand that the Practice cannot condition treatment of the Patient on whether I sign this Authorization, and that my decision not to sign will not influence or affect the Patient's treatment in any way.

NAME OF PATIENT _____

DOB OF PATIENT _____ PMS NUMBER _____

SIGNATURE OF PATIENT OR PARENT/LEGAL GUARDIAN
(if signing for minor) _____

PRINTED NAME OF PARENT OR GUARDIAN
(if signing on behalf of minor child) _____

DATE OF SIGNATURE _____

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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 _____