AESTHETICA COSMETIC AND LASER SURGERY CENTER, P.C.

PATIENT INFORMATION SHEET

Patient Name	Birth Date	Age
Gender (M/F)	Home Phone	Cell Phone
Street Address	City/State	Zip Code
Patient's Employer	Occupation (Indicate if Student)	
Emergency Contact	Home Phone	Mobile Phone
Family Doctor	Address	Business Phone

PREFERRED Phone Number for CONFIRMATIONS and COMMUNICATION

Referral Source: Internet_____Friend_____(Name_____) Previous Patient_____

Aesthetica's Website_____ Other_____

Aesthetica likes to keep our patients informed of what's new at the Center plus specials that we may having coming up in the future. We do this via email communication. If you would like to be included in these mailings, we are required to have your signed consent that you agree to email communications from Aesthetica.

_____ I agree to email communications from Aesthetica Cosmetic & Laser Center

Email Address: _____

_____ I DO NOT want email communications from Aesthetica Cosmetic & Laser Center

Signature _____ Date_____

I understand there is a non-refundable fee of $100 for the initial consultation only with Dr. Vasily, there would be a non-refundable fee of $50 for the consultation only with Kelly L., R.N. I understand that all other fees will be explained to me when I appear for the consultation. In the event I DO NOT appear for my scheduled appointment, I agree that in consideration of Aesthetica Cosmetic and Laser Surgery Center, P.C. scheduling an appointment and reserving a space on the schedule for a consultation for me, Aesthetica Cosmetic & Laser Center, P.C. is authorized to charge the cost of the initial consultation fee.

Signature: _____ Date: _____

Aesthetica Cosmetic & Laser Center

Financial and Insurance Policy

- **It is the policy of Aesthetica Cosmetic & Laser Center to have a Financial and Insurance Policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with optimal care when addressing your aesthetic and medical concerns. This Financial and Insurance Policy was created in an effort to avoid any misunderstandings or disagreements concerning payment and/or coverage for professional services.**

Please read the following carefully:

1. **Aesthetica does not accept or participate in any insurance plans nor are we responsible for prescription plan coverage:**

    a. Treatments provided at Aesthetica are not able to be submitted to insurance companies.
    b. Aesthetica does not have knowledge as to whether or not a prescription given to the patient will be covered by the patient's insurance plan. The prescription given is the prescription that Dr. Vasily feels is best suited for your medical concern(s). If you are unable to attain a prescription written by Dr. Vasily due to coverage and/or cost; you may contact your insurance agent or provider to request a copy of your prescription formulary. The patient is responsible for knowing their own prescription formulary. Once you have obtained the prescription formulary, kindly contact our office with the information and Dr. Vasily will review your formulary and provide you with a prescription that meets your insurance company's requirements.
    c. We do not write pre-authorizations for prescriptions. If your insurance company rejects a prescription and requests a pre-authorization; kindly provide our office with your prescription formulary and we will have Dr. Vasily review the formulary for a covered prescription.

Consent for Financial Responsibility of Non-Covered Services

I understand that all services performed at Aesthetica Cosmetic & Laser Center are considered cosmetic and not covered or reimbursed by my insurance carrier. I agree to be financially liable for any payments incurred for these services.

Patient Signature:_____ Date:_____

2. **Patient Financial Responsibility:**

a. Payment is due at the time of service and/or at the time the product(s) are received.
b. Payment Options: Cash, checks and all major credit cards (Visa, MasterCard, Discover, American Express.)

PLEASE NOTE: If paying by check, there is a $30 fee for all returned checks. A $25 administration fee if the account is forwarded to collections for non-payment.

c. Any accounts that remain outstanding, whether for a procedure fee or a cancellation fee will be forwarded to the collection agency after 5 consecutive billing cycles.
d. NO INTEREST[1] Payment Plans[2] from CareCredit®.
   - Convenient, low monthly payment plans are available.
   - No annual fees or pre-payment penalties.
   - Prior approval is required. You are welcome to inquire at the front desk for more information on this plan.

[1] If paid within the 6 month promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.
[2] Subject to credit approval.

Cancellation Policy

a. Our office policy for cancellations is a 24 hour notice. Outlined below is our policy on less than a 24 hour notice of cancellation and for any missed appointments in our office.

• Missed Consultation appointment with Dr. Vasily:	$100
• Missed Consultation appointment with Kelly, R.N.:	$ 50
• Missed follow up appointment with Dr. Vasily, R.N. or technician:	$ 50
• Missed treatment appointment with Dr. Vasily, R.N. or technician:	$100
• Missed Botox® or Juvederm® appointment will be billed at the treatment cost.	
• Cancellation notice is less than 24 hours:	$ 50

My signature on this document confirms that I have read and will adhere to Aesthetica Cosmetic & Laser Center Financial and Insurance Policy and the Cancellation Policy.

Patient Signature:_____ Date:_____

Print Name:_____

AESTHETICA COSMETIC AND LASER CENTER

Effective 7/2/18

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Although this practice is NOT required by law to provide you with this Notice our medical director has made a decision to treat our practice as a HIPAA compliant practice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this notice. If you should have any questions pertaining to this notice, please contact our Business Manager Sheila Hayes at **sheila@aclsc.com**.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are seen at our practice, a record of your visit is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate health professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- **For Treatment**. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other practice personnel who are involved in your health care. For example, a provider treating you for an injectable may need to know if you are taking blood thinners because it may affect the end result of the treatment or could potentially cause more bruising. In addition, the provider may need to tell a treating technician of a condition or medications you are taking in order to treat you safely. Essentially different treating employees of this practice may also share your health information in order to coordinate your care and provide you with treatments, medication, lab work and doppler scripts. We may also disclose health information about you to people outside the practice who may be involved in your medical care. This may include family members.
- **For Payment**. This practice does not bill insurances, all payments are made at the time of visit. However, your protected health information may be shared with the Business Manager for collections purposes if a form of payment is not valid.

- **For Health Care Operations.** We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many patients to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the practice including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of the practice. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of our patients.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates**. There are some services provided in our practice through contracts with business associates. Examples include medical directors, outside attorneys and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Providers**. Many services provided to you, as part of your care at our practice, are offered by our Medical Director, Physician Assistant, Nurse, Laser Technicians, Esthetician.
- **Treatment Alternatives**. We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services and Reminders**. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.
- **Military and Veterans**. If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Research**. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research procedure may involve comparing the health and recovery of all patients who received one treatment to those who received another, for the same condition. All research procedures, however, are subject to a special approval process. This process evaluates a proposed research procedure and its use of health information, trying to balance the research needs with patients' need for privacy of their health information. Before we use or disclose health information for research, the procedure will have been approved through this research approval process. We will also require your signature on a research release form in order for you to participate in a research procedure. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave the practice.
- **Workers' Compensation**. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting** Federal and state laws may require or permit the practice to disclose certain health information related to the following:

- *Public Health Risks*. We may disclose health information about you for public health purposes, including:
  - Prevention or control of disease, injury or disability
  - Reporting births and deaths;
  - Reporting child abuse or neglect;
  - Reporting reactions to medications or problems with products;
  - Notifying people of recalls of products;
  - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
  - Notifying the appropriate government authority if we believe a resident has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- *Health Oversight Activities*. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a patient, spouse or someone in the patient's care has been the victim of abuse, neglect or domestic violence.

Law Enforcement. We may disclose health information when requested by a law enforcement official:

In response to a court order, subpoena, warrant, summons or similar process;

To identify or locate a suspect, fugitive, material witness, or missing person;

About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;

About a death we believe may be the result of criminal conduct;

About criminal conduct at the practice; and

In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of the practice, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy**. With some exceptions, you have the right to review and copy your health information.

  You must submit your request in writing to our Business Manager at sheila@aclsc.com. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- **Right to Amend**. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. We are not obligated to comply with this request if our practice feels the information you are requesting to have amended is correct. You have this right for as long as the information is kept by or for the practice.

  You must submit your request in writing to sheila@aclsc.com. In addition, you must provide a reason for your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

  Is not part of the health information kept by or for the practice; or

  Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

You must submit your request in writing to sheila@aclsc.com. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You must submit your request in writing to sheila@aclsc.com. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Alternate Communications. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

You must submit your request in writing to sheila@aclsc.com. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time.

You may obtain a copy of this Notice at our website, www.ilovemyskin.com.

To obtain a paper copy of this Notice, contact Sheila Hayes at sheila@aclsc.com.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in the practice and on the website. The Notice will specify the effective date on the first page, in

the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Business Manager.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Business Manager, Office of Civil Rights or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, contact Sheila Hayes at ***sheila@aclsc.com***. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth _____

Address:_____

Practice Name: Aesthetica Cosmetic and Laser Center

I have been given a copy of (Aesthetica Cosmetic and Laser Center)'s *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that (Aesthetica Cosmetic and Laser Center) has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Business Manager, or by visiting the (Aesthetica Cosmetic and Laser Center's) web site at **ilovemyskin.com**.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Practice Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

_____

Completed by:

_____ _____
Signature of Practice Representative Date

_____
Print Name

FILE ORIGINAL IN PATIENT'S RECORD.

Aesthetica
Cosmetic and Laser Surgery Center
1342 Chelsea Ave., Rear

PATIENT COMMUNICATION FORM

PRINTED NAME: _____ DATE: _____

A. Family and Friends. It is the office policy of Aesthetica Cosmetic and Laser Surgery Center, P.C. not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (✓) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____ _____ Yes _____ No

Parent: _____ _____ Yes _____ No

Other: _____ _____ Yes _____ No

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communications, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____ By Home Phone

_____By Mobile Phone _____ By Business Phone

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

Aesthetica
Cosmetic and Laser Surgery Center
1342 Chelsea Ave., Rear
Bethlehem, Pa. 18018
Phone: 610-861-9469

Patient Consent for Photography

Patient Name:_____ Date:_____

☐ Check here if you are a minor or unable to provide consent

I consent for photographs to be taken of me or my child (or person for whom I am legal guardian) for purposes of treatment for a condition or overall rejuvenation, I understand that the information will be used in my patient record, for purposes diagnosis, tracking my progress, progression of a condition, rejuvenation, treatment purposes, keeping a visual history, medical teaching and reporting to referring physician. Please keep in mind refusal may limit our ability to track your progress or progression of a condition if we do not have visual documentation. In certain instances, dependent upon the nature of the treatment, we may not be able to continue with treatment without baseline photographs. I understand that I am able to withdraw my consent at any time. However, the withdrawal of consent will not alter retention of photographs taken prior to the withdrawal.

- To withdraw my consent in the future or for questions pertaining to patient rights, I may contact the Business Manager – Sheila Hayes via email at sheila@aclsc.com

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By signing below, I confirm that this consent has been explained to me in terms in which I understand.

1) I consent for my photographs to be used in patient record as part of my visual patient history for purposes of diagnosis, tracking my progress or progression of a condition and/or treatment, which may be shared with other laser technicians (within the practice) to show how well a device is working and to provide a copy of my medical image(s) to include at a referring physician's office, upon request.

   _____(Signature) _____(Witness)

2) I DO NOT consent to any images to be taken. I understand that refusal to consent to images taken as part of my patient record may limit my provider's ability to effectively track my progress or progression of a condition and given the nature of certain treatments my refusal to allow photographs may prevent me from continuing with the elected treatment

   _____(Signature) _____(Witness)

Aesthetica Cosmetic & Laser Surgery Center
PATIENT HISTORY

Patient Name**:** _____ Date: _____ Age**:** _____

Main Concern: _____ Referring doctor: _____

MEDICATIONS: Anticoagulants (ex. ASA, ibuprofen, Coumadin, Xarelto, etc) _____

Prescription: _____

Non-Prescription:_____

Supplements/Vitamins (including Fish Oil): _____

SKIN CARE: _____

ALLERGIES:
____Lidocaine ____Novocain
____Food Allergies
____Seasonal/Environmental
____Other Allergies _____

P.H.: ___Smoking: # per day ___
___Alcohol: how often ___

MEDICAL HISTORY: (*please check what applies to you*)
____Hypertension
____Heart Murmur
____Heart Arrhythmias (ex, A-fib, palpitations)
____HIV Exposure
____Prophylactic Antibiotics
____HX Abnormal Bleeding, Bruising, Scarring
____Pacemaker or ICD Implant
____Skin Cancer: Type_____
Location_____
____Gold Therapy
____Metal Implants (Location_____)
____Tanning HX:
Type_____ Year____
Natural Tanning # of exposures_____
Artificial Tanning # of exposures_____

___Diabetes
___HX Hepatitis (Type___)
___ Epilepsy or seizures
___GI disorder
___Herpes Simplex Virus (Cold Sores)
___Wear contacts
___Glaucoma, Cataracts, or dry eyes
___Menopause: # of years____

___ Other medical condition(s) not listed: _____
___ Permanent/Cosmetic Tattoo
___ Dental Work: Type_____ Year____

SURGERIES: (Cosmetic and Other)

_____

_____

I hearby acknowledge that all information on this form is complete and true to the best of my knowledge.

Patient/Legal Guardian:_____ Date: _____