

ABOUT FACE

aesthetic centers

THE FOLLOWING PERTAINS TO PRIVACY OF YOUR HEALTH INFORMATION

Under the Health Insurance Portability & Accountability Act (HIPAA) most physicians are required by law to provide you with notice of legal duties and privacy policies with respect to your personal health information (PHI).

You have the right to inspect or copy your PHI.

You have the right to request your PHI be amended.

You have the right to receive an accounting of disclosures of your PHI.

You have the right to file a complaint with the Department of Human Services.

Your PHI may be disclosed for the following reasons:

At your written request

To coordinate treatment with other persons participating in your healthcare

Payment

Judicial or law enforcement agencies or regulatory agencies

Your signature below confirms you have been provided a copy of the Privacy Act.

Patient signature: _____ **Date:** _____

Office and Financial Policies

We at *About Face Aesthetic Centers, LLC* would like to thank you for your business. To keep you updated and informed of our office policies, we ask that you read and sign this acknowledgement prior to any treatment.

- Payments:** Payments for all services and consultations are due before the service. No interest financing is available for those who qualify. Valid ID must be presented with all credit card and check transactions.

- Returned Checks/Rejected ACH Withdrawals:** A \$50 charge will be incurred for any cancelled checks or returned ACH payments. Postdated checks will not be accepted.

- Appointments:** A major credit card is required to reserve appointments. Clients should arrive 15 minutes prior to the appointment time and plan to stay 15 minutes after the service for post procedure observation. We reserve the right to charge for any appointment cancelled without 24 hours notice. Missed appointments will be billed at the full price of the service scheduled. When the service is not known, a \$50 charge will be incurred.

- Medical Records:** A copy of your medical records is available upon your written request. Copies will be charged at \$.50 per page, please allow 4-7 days for copies to be made.

- We do require a credit card number to reserve your space on the schedule,** it will be one file 'till the day of your appointment. We will give you a reminder call a few days before your appointment – if you need to make any changes to or cancel your appointment you can, but we need at least 24 hours notice. If you change or cancel with less than 24 hrs notice, or for no-shows, your card will be charged the cost of the service the day of your appointment.

I acknowledge full financial responsibility for services rendered by *About Face Aesthetic Centers, LLC*. I understand that I am responsible for prompt payment of the entire balance before the procedure. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges as outlined in office and financial policy guidelines.

Signed _____ Date _____

Printed Name _____

Personal Treatment Plan

Designed for	Date:
Designed by	Telephone:
These are areas of concern for me (Rank you top 5 concerns): * Fine lines and wrinkles _____ * Smile lines around nose and mouth _____ * Rough texture of skin _____ * Tired looking skin _____ * Sagging skin _____ * Hair on face _____ * Uneven skin tone _____ * Acne _____ * Dark circles under eyes _____ * Freckles/Lentigos _____ * Dryness _____ * Scars _____ * Rosacea _____ * Migraine _____ * TMJ pain _____ * Cellulite _____ * Areas of fat _____ * Excessive sweating _____ * Other _____	Comments and additional instructions:

STAFF USE ONLY	Treatment Schedule
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	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Botox												
Dysport												
Juvederm												
Restylane												
Radiesse												
Facial												
Chemical Peel												
Microdermabrasion												
E-Light												
VelaShape												

Home Maintenance

Morning	Evening