AESTHETIC SURGERY INTAKE & FINANCIAL INFORMATION

PATIENT

(Legal Last Name):_____________________(Legal First Name):______________________(MI):_____

Birthdate: ______________________ AGE:______________ MALE / FEMALE

Street Address: ________________________________City:__________________ State:_____ Zip:__________

Occupation:_______________________________ Employer:____

COMMUNICATION

Preferred Method of appointment confirmation (circle): Text Message Email Telephone call

Hm Phone:_______________________ Work:_______________________ Cell:_______________________

BEST phone number (please circle): HOME WORK CELL OTHER:_______________________

E-Mail Address:____________________________________ (Used for appointment confirmations & specials)

May we leave a voicemail and communicate via email? Yes / No

NOTIFY IN CASE OF EMERGENCY

NAME:____ RELATIONSHIP:______________________

Hm Phone:________________________ Work:_______________________ Cell:_______________________

PRIMARY CARE PHYSICIAN: _______________________________ OFFICE PHONE: ______________________

HOW WERE YOU REFERRED TO OUR OFFICE - We like to thank our referrals!

INTERNET or SOCIAL MEDIA: Google Main Website YELP Facebook Other?___________________________

PUBLICATION: Women's Edition Boulder Lifestyle Boulder County Lifestyle Daily Camera Broadlands Legacy

REFERRING FRIEND / RELATIVE / PHYSICIAN: ____

Office Use Only

Follow-up	*Date*	*Completed By (name)*
☐ Requested Information provided		
☐ Follow-up requested		
☐ Consultation scheduled		
☐ Referral thank you / voucher sent *Comments:*		

2595 Canyon Blvd., Suites 350 & 360 | Boulder, CO 80302 | 303-440-7546 | www.AuraBoulder.com | www.AuraLiposculpture.com

Notice of Privacy Policy

Certain government regulations, known as Health Insurance Portability and Accountability Act of 1996 (HIPAA), require medical providers to explain their privacy and security policy so that information obtained by us about you is used appropriately.

***How we may use and disclose Protected Health Information (PHI) about you:**

- Treatment, management and coordination of your health care needs.
- Payment of any and all medical claims.
- Normal operation of our business, such as quality review and training of our staff.
- Communication from our office, such as to contact you to verify appointments, or to leave a message on voicemail with test results or to answer questions.
- As required by law, to include but not limited to Public Health activities, abuse issues and legal proceedings.

***Your rights regarding PHI about you:**

- You have the right to request restrictions.
- You have the right to receive confidential communications.
- You have the right to inspect and copy PHI about you (a charge may apply for copies received).
- You have the right to request that we amend your PHI.
- You have the right to receive an accounting of disclosures.
- You have the right to obtain a paper copy of our complete Notice of Privacy Practices.

Restrictions Requested:

____

____

____

Signature: ____ **Date:**________________

(To acknowledge receipt of this policy)

**This is not a complete listing of our Privacy Practices. Please ask to see our complete Notice of Privacy Practices.
***We reserve the right to make changes to this Notice and make such changes effective for all PHI we may already have about you. We will post any and all changes in a prominent location, and provide you a copy upon request.

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Payment Information & Options:

A 20% *Non-Refundable* deposit is required at the time of scheduling, and the remaining balance is due at least 2 WEEKS PRIOR to the procedure date (typically collected upon arrival at the pre-op appt). If interested, please ask about M-Lend financing – we are happy to assist you with the process. We provide a number of payment options which may be used individually or combined:

- Cash, Check, Visa, Mastercard, AMEX, Discover, M-Lend Financing
- PAYMENT: If payment is made less than two weeks before surgery, your options for payment are limited to cash, credit card or cashier's check. Personal checks will NOT be accepted within two weeks of surgery.
- $50 service charge for each returned check

Patient Cancellation and Rescheduling Policy:

We understand you may decide to postpone your surgery. We request your courtesy and understanding that changes in a surgical schedule affect not only Dr. Roesner, the procedure/OR staff, but other patients and their families as well

- More than two weeks prior to the date of surgery, surgical fees will be refunded, less the 20% deposit. We will apply the 20% deposit ONE TIME ONLY *within (30) days* toward the rescheduled procedure
- There is a $350 rescheduling fee for ***ALL*** procedures re-scheduled within 7 days of surgery. It is incredibly difficult to fill a surgical spot within a week of surgery.

Revision Policy:

- Surgery fees are inclusive of all pre and post-surgery related visits as well as revisional surgery deemed necessary by the original surgeon *within 6 months* of the initial procedure
- There is a $350 rescheduling fee for procedures re-scheduled within 7 days of surgery
- Hospital fees for anesthesia, medication, and facilities associated with revisional surgery are not included in this fee estimate

Insurance & Other Expenses:

- This proposal is for elective cosmetic surgery procedure(s). Elective surgical procedures are not covered by insurance. Therefore, Aura Liposculpture & Plastic Surgery will not bill insurance
- Some expenses (if necessary) often covered by insurance: prescription medication, advance lab work, EKG, and additional fees related to post-surgical complications
- Out of pocket expense: comfort garment may be recommended for select procedures
- *Hospital Procedures:* Dr. Roesner is confident with the amount of time he has estimated for your procedure and length of stay. However, in the event this estimated time is exceeded, or unforeseen complications arise, you may be billed for additional facility and anesthesia care costs.

I have read and understand the above information:

Patient's Signature____ Date:______________________

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The information below is necessary for the evaluation of your procedure:

Area(s) of interest for your consultation:

____

____

Please answer the following questions on a scale of 1-5 by circling the appropriate number

When looking 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 &/or loose skin

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

When looking in the mirror at my face and neck, I am not concerned, somewhat concerned, or very concerned about the appearance of my age spots/discoloration

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

AREAS OF INTEREST (please circle all that apply)

□ Skin Analysis	□ Acne	□ Body Contouring or Fat Transfer
□ Skin Care Product	□ Redness	□ Loss of Facial Volume/Fullness
□ Facial Fine Lines	□ Skin Texture	□ Toxin free alternative to Botox
□ Face or Neck Wrinkles	□ Blotchy Skin	□ Chest or Stomach
□ Loose or Sagging Skin	□ Liver Spots or Age Spots	□ Thin Lips
□ Hair Removal	□ Spider Veins	□

Are you interested in receiving a complimentary consultation to address your cosmetic skin interests? □ YES □ No thanks

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Please complete the following:

1. Do you have any allergies to medications and/or latex? Yes / No
If yes, list: ____

2. Please list current prescription and non-prescription medication you take
____
____

3. Do you take any food supplements? Yes / No
If yes, list: ____

4. Do you have any medical issues or diagnoses? Yes / No
If yes, list: ____
If yes, current treating physician ________________________ ph________________________

5. Have you had any previous surgeries? Yes / No
If yes, list and date:____
____

6. Have you had any previous cosmetic surgeries / liposuction? Yes / No
If yes, list and date:____

7. Have you had a surgical fat transfer? Yes / No
If yes, list and date:____

8. Do you have a history of Anemia or Bleeding Tendencies? Yes / No

9. Have you had children? Yes / No n/a If yes, number____ Ages__________________

10. Type(s) of delivery/ies: N/A __________Vaginal _________Cesarean Section

VAGINAL REJUVENATION CLIENTS ONLY:

1. Do you have loss of urine when coughing or sneezing? Yes / No
2. Do you have pain or discomfort with intercourse? Yes / No
3. Do you have pelvic and/or menstrual pain? Yes / No

I consent to a gynecologic/pelvic exam and diagnostic photographs

Signature____ Date _________________

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The use of photographs is essential to the planning and evaluation of aesthetic plastic surgery and many non-surgical or laser procedures. Your procedure will be photographically documented before, possibly during, and after the procedure. These photographs are a permanent part of your medical record, and will never be shown to anyone else without your consent.

Print Name: ____

Signature ____ Date___________________

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