KDS Aesthetics
Demographics, Policies, Consent to Treat, & HIPAA

Chart#_____

Date First Middle Last Nick Name

Gender: Male / Female Date of Birth: _____ SSN:_____ Race: _____

Marital Status: Single / Married / Widow / Divorced / Separated Significant Other's Name:_____

Mailing & Billing Address(es):_____

Cell Phone: _____ Other phone:_____

Email:_____ Contact method(circle all that apply): Text, call, email

Who is responsible for your medical bills (and relationship)?_____

Phone # for person responsible to bills:_____ DOB/SSN person responsible to bills:_____

Emergency Contact Name/Number:_____ Relationship to you:_____

Policyholder/Relationship/DOB(name on the policy):_____ Ins Co:_____

Policyholder's Employer:_____

Secondary Insurance: _____

Policies: Clients are seen by appointment only, please call 252-299-2910. For urgent concerns, call: 252-962-8822
Please have with you: your insurance card(s), picture ID and your payment. If we cannot verify your coverage, you will be required to pay at the time of the visit. If you have a deductible, copay, or coinsurance, you will be required to pay that at each appointment. If cash or check is not your payment method, a 3% (three) convenience fee may be charged.
Cosmetic/non-medically necessary treatments: Prior to performing a treatment or surgery, 100% payment of the service(s) may be required. A non-refundable scheduling fee may be required to book a surgery.
Appointments: If you are late for your appointment, you may be rescheduled to the next available appointment. Should you fail to cancel your appointment 24 business hours before your appointment time you may be charged a no-show fee.
Credit Card Policy: We require that all patients have a credit card on file with our office. Credit cards on file will be used to hold your appointment time and to pay no show fees and account balances if you have an outstanding balance.
To All Patients (Must be signed by the patient, parent, or legal guardian) By signing below, I (the undersigned) acknowledge it is my responsibility to notify KDS Aesthetics, PLLC, of all changes to my account as claims will be my responsibility if denied for exceeding time limit for filing. This includes but is not limited to phone #'s, addresses and insurance information. I agree by signing below I will take full responsibility for my account. I will be responsible for any unpaid balances that my insurance company does not pay. I understand it is my responsibility to see that my insurance company processes claim(s) according to my benefits. I understand that KDS Aesthetics PLLC is not responsible for knowing my benefits. For billing statements, the biller will add a late fee if a second statement is sent. If payment is not received promptly, the credit card on file will be charged for the full amount of your delinquent bill. If I dispute any charge with my credit card company, I agree to pay my provider $200 chargeback fee and understand that my provider has the right to share necessary information about my procedure(s) or billing with my credit card company to resolve the dispute.
Assignment of benefits: I authorize the release of medical information necessary to process claims for all services rendered to me by KDS Aesthetics, PLLC. I assign all medical and/or surgical benefits, including major medical to which I am entitled to KDS Aesthetics PLLC. The assignment of benefits will remain in effect unless revoked by me in writing. By signing below, I acknowledge that I have read this document in its entirety and the information provided by me is accurate to the best of my knowledge.
By signing this form, I have read and reviewed the long form of the policies, consent to treat and HIPAA form and agree to those terms explained in that paperwork.

Signature:_____Date:_____

4082 Capital Drive, Rocky Mount, NC 27804 | 2806 Wooten Blvd, Suite B, Wilson, NC 27893
Phone: (252) 299-2910 | Fax: (970) 293-5677 | DrS@KDSAesthetics.com

KDS Aesthetics
Demographics, Policies, Consent to Treat, & HIPAA

Chart#_____

_____

Date First Last

HIPAA Waiver: Our Notice of Privacy Practices provides information about how we may use or disclose protected health information and your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- Protected health information and/or billing information may be used to confirm services rendered to patient if credit card company attempts to rescind patient's payment for services performed
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? **YES NO**
May we leave a message on your answering machine at home or on your cell phone? **YES NO**
May we discuss your medical condition with any member of your family? **YES NO**

If YES, please name the members allowed:_____

Consent to Treat: I consent to the treatment deemed necessary by the health care providers of KDS Aesthetics, PLLC upon my presentation to KDS Aesthetics for medical services. I consent to the disclosure of any information to outside providers or agencies involved in my treatment as deemed necessary by my KDS Aesthetics provider or if such disclosures are required or permitted by law. I consent for KDS Aesthetics to release any information and photographs required in the course of my examinations and treatment for the purposes of insurance and/or Medicare benefits payment and/or board examination process. Workman's compensation claim information may be leased to my employer. I consent to assignment of payment directly to KDS Aesthetics of all medical benefits applicable and otherwise payable to me through insurance and any other source.

I consent for KDS Aesthetics to act on my behalf in the collection of benefits from insurance carriers through whatever means deemed necessary and the endorsement of benefits checks made payable to me or KDS Aesthetics.

I consent for KDS Aesthetics to view my external prescription history via RxHub Service – which will include history from other unaffiliated medical providers, insurance companies and pharmacy benefit managers.

Medicare Patients

I request that payment authorized Medicare benefits be made on my behalf by KDS Aesthetics, PLLC. For any services provided to me by providers of KDS Aesthetics PLLC to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of benefits payable for related services. This assignment will remain in effect unless revoked by me in writing. A photocopy of this assignment is to be considered valid as the original.

Signature:_____Date:_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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KDS Aesthetics
Patient Information

Chart#_____

Patient Name: _____ DOB: _____ Today's Date:_____

Reason for Visit: _____

How did you hear about us? _____

Occupation: _____ Job Activity Level: ☐ **LOW** ☐ **HIGH**

Exercise: (type & frequency) _____

Allergies: _____ Family History: _____

Tobacco Use: (check one) ☐ **NEVER** ☐ **QUIT, How long ago?_____** ☐ **YES**

Alcohol Use: (check one) ☐ **NEVER** ☐ **OCCASIONAL** ☐ **HEAVY**

Medications: _____

Medical History: _____

Previous Surgeries: _____

Please check "yes" or "no" for each of the below items as they apply to your health:

ALLERGIC/IMMUNOLOGIC:	YES	NO
Lupus	☐	☐
Scleroderma	☐	☐
CARDIOVASCULAR:		
Fainting Spells	☐	☐
Difficulty Lying Flat	☐	☐
HTN/Heart Disease	☐	☐
CONSTITUTIONAL:		
Weight Loss	☐	☐
Weight Gain	☐	☐
Large Breasts	☐	☐
Sagging Breasts	☐	☐
EAR, NOSE, THROAT:		
Sinus Trouble	☐	☐
Nasal Stuffiness	☐	☐
Nasal Injury	☐	☐
ENDOCRINE:		
Diabetes	☐	☐
Thyroid Disease	☐	☐
EYES:		
Glasses, Contacts	☐	☐
Heaviness	☐	☐
Bagginess	☐	☐

GASTROINTESTINAL:	YES	NO
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Ulcers	☐	☐
GENITOURINARY:		
Kidney Disease	☐	☐
HEMATOLOGY/LYMPHY:		
Easy Bruising	☐	☐
Cancer: (type) _____	☐	☐
Anemia	☐	☐
Blood Clots	☐	☐
Easy Bleeding	☐	☐
MUSCULOSKELETAL:		
Joint Pain	☐	☐
Muscle Pain	☐	☐
Neck Pain	☐	☐
Back Pain	☐	☐
Shoulder Pain/Grooving	☐	☐
NEUROLOGICAL:		
Loss of Strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Seizures	☐	☐

PSYCHIATRIC:	YES	NO
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Substance Abuse	☐	☐
RESPIRATORY:		
Sleep Apnea	☐	☐
Shortness of Breath	☐	☐
SKIN:		
Skin Infection/Lesions	☐	☐
Rashes/Sores	☐	☐
Itching/Burning	☐	☐
Scarring/Keloids	☐	☐
Skin Disorder	☐	☐
Cold sores/Herpes	☐	☐
Loss of Facial Volume	☐	☐
Unwanted Wrinkles	☐	☐
Dullness	☐	☐
Dark Spots	☐	☐
Acne	☐	☐
FEMALES ONLY:		
Last Mammogram:	_____	
ABNORMAL?	☐	☐
Pregnant	☐	☐

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