



Patient Questionnaire

Greeting (circle one): **Mr.** **Miss** **Mrs.** **Ms.**

Last Name **First Name** **MI** **Date**

Address **State** **Zip Code**

Sex: **M** **F** **Marital Status:** **S** **M** **D** **W**

Social Security Number **Date of Birth**

Home Phone **Work Phone** **Alternate / Cell**

Occupation **Responsible Parent (if PT is a minor)**

Email Address: _____
(if you wish to be notified of events, discounts, & promotions)

Emergency Contact: _____ **Phone:** _____

Circle the names of any surgeons you have seen for a consult or treatment at SPS:

- Dr. DeLoach Dr. Ruf Dr. Vann Dr. Davies Dr. Pettigrew Dr. Pearl

Were you referred by a friend or physician? _____ If so, who? _____



The Skin Institute Policies

I. All services provided by the specialists and physicians in this office are on a fee for service/product basis. All services and product purchases are payable the day of purchase/treatment. Insurance does not cover services provided by The Skin Institute.

II. Cancellation Policy

In order to keep your cost down, the Skin Institute policy on cancellation and no-show appointments is as follows:

- In the event you need to cancel your appointment you must do so within 24 hours before the scheduled service. There is a \$30.00 charge per half-hour slot for appointments canceled less than 24 hours in advance.
- Treatments requiring more than one hour reserved time (i.e. Obagi Blue Peel, Superior Skin Evaluation, etc.) will require a deposit of 25% at time of booking to be applied to the treatment fee. This deposit will be forfeited without the 24-hour cancellation or in the event of a no-show. If a gift certificate is being used to pay for the treatment, it will be voided.

III. Product Return Policy

The Skin Institute will accept returns on products within 14 days of purchase for a credit towards future purchases or treatments. There is no refund on in-office treatments.

IV. “Complementary Follow Up Visits”

Our policy is to see all patients that are on a protocol of products from our facility without fee. Most products, if used as directed, are consumable within three months. After this period of time, we are unable to verify whether the product was purchased from our facility and will assume it was purchased from another source. An office visit fee of \$30.00 per half hour appointment slot will be charge for visits concerning home treatment protocols if a product has not been purchased within three months from our facility.

V. Prescription Medications

Medications prescribed by our physicians must be validated by an office visit. Prescription medications will not be mailed or called-in for patients that have not been seen within a three month period at our facility.

VI. Photo Agreement

I consent that the Skin Institute under the following conditions may take photographs of me: a competent photographer approved by my physician or esthetician shall take the photographs. These photographs shall be used for medical records only to record my progress at the Skin Institute. I shall be contacted for additional consent prior to these photographs being used for medical research, education or other purposes other than charting my progress.

Patient’s Signature: _____ **Date:** _____ **Witness:** _____

VII. Patient Agreement

I understand that I am responsible for any balance due for professional services and product purchases and understand that I am responsible for payment at that time.
I have also read and understand the Skin Institute Cancellation, Insurance, and Product Return policies.

Patient’s Signature: _____ **Date:** _____ **Witness:** _____



7208 Hodgson Memorial Drive
Savannah, GA 31406

Savannah Plastic Surgery Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print) _____

Relationship to patient: _____

Patient Signature: _____

Date: _____

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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The Skin Institute at Savannah Plastic Surgery General Treatment Consent Form

The Skin Institute Clinical Treatments may consist of waxing, tinting, cleansing, mechanical and/or chemical exfoliation, steam, extraction with sterile instruments, tonic rinsing, mask or superficial peeling application, superficial sanding with aluminum oxide crystals and an anti-inflammatory treatment. Clinical treatments take approximately 15 minutes to one hour and are designed to cleanse, exfoliate, and restore the skin as much as possible in the allotted time.

PLEASE READ CAREFULLY

Aggressive use of glycolic, benzoyl peroxide, retinoic acid and vitamin C home care products as well as over-scrubbing, picking and sun exposure can cause temporary dryness, irritation and dark spots following the procedure.

Patients that have had Accutane therapy, chemical hair or face treatments may be more prone to post treatment complications including burns, scabbing and patches of hyperpigmentation. Please advise your esthetician if you have had any of these treatments within the past two weeks to six months.

Patients that have used Retinoic Acid products within 48 hours of their scheduled treatment may not have a 30% Glycolic Peel or a Salicylic Acid Peel. Please inform your esthetician or physician if you are taking Accutane or have used Retin-A so that you may be rescheduled.

Wait at least 24 hours before applying acne medications and glycolic-based products or using scrubs or depilatories. Since the skin may be more sensitive to extraction discomfort during a woman's menstrual cycle, please schedule accordingly.

Rarely, an allergic reaction occurs. Treat allergic reactions the following way:
Call the office (912) 351-5050. SPSA Physicians are on call 24 hours a day. Temporarily discontinue the use of all products, except sunblock. Apply cold compresses hourly. Reaction symptoms usually disappear in a day or two.

Dryness, sensitivity, redness, small scabs, small cuts, and flaking are possible temporary side effects of a MicroPeel, MicroPeel Plus, waxing, Microdermabrasion or clinical facial treatment. Mild, superficial temporary dark spots will occasionally occur after the extraction of older or deeper lesions and will fade rapidly.

YOU MUST AVOID THE SUN and use your prescribed post-treatment protocol exactly as directed. This will reduce the formation of new lesions and help fade and exfoliate existing spots.

Your Skin Care Specialist will wear surgical gloves throughout the procedure. Everything else used will be disposable or sterilized.

CONSENT FOR TREATMENT

By signing below, I hereby consent to a clinical facial treatment or waxing procedure (MicroPeel, MicroPeel Plus, Microdermabrasion or Clinical Facial Treatment). This consent will serve as my consent for future treatments. I have informed the clinic of any health problems I may have, and any and all medications I am taking, especially Accutane or Retinoic Acid Creams.

Patient's Name: (Print) _____ Date: _____

Patient Signature (or Guardian) _____

Witness: _____