326 W. Craig Place
San Antonio, TX 78212
210.692.3000

BUCAY
CENTER FOR
DERMATOLOGY AND AESTHETICS

18707 Hardy Oak Blvd.
Suite 101
San Antonio, TX 78258
210.370.9995

PATIENT HISTORY QUESTIONNAIRE

Patient Name _____ Date _____

Reason for your visit today _____

_____

PATIENT HISTORY

Medications (including RX, Birth Control Pills, Aspirin, Supplements and other OTC medications _____

_____

Drug Allergies_____

Do you have adverse reactions to dental anesthesia? If yes what reaction?_____

_____

FAMILY HISTORY / PERSONAL MEDICAL HISTORY (DID YOU EVER HAVE?)

Skin Cancer_____

Melanoma_____

Unusual Moles_____

Asthma	Y N	Keloids	Y N
Hepatitis	Y N	Bleed Easily	Y N
Pacemaker	Y N	Skin Cancer	Y N
Diabetes	Y N	Melanoma	Y N
Ulcers	Y N	HIV +/AIDS	Y N
Hypertension	Y N	Risk Factors for HIV	Y N
Glaucoma	Y N	Mitral Valve Prolapse	Y N
Tuberculosis	Y N	Cardiac Disease	Y N
Liver Disease	Y N	Gastrointestinal Disease	Y N
Kidney Disease	Y N	Arthritis	Y N
Cancer	Y N	Psychiatric History	Y N

Other than the services we have already provided for you, What additional services would you like to learn about? Please check all that apply.

- ❒ Customized Skincare
- ❒ Acne
- ❒ Melasma
- ❒ Uneven skin tone
- ❒ Blotchy Skin
- ❒ Skin discoloration
- ❒ Rough skin texture
- ❒ Rosacea/Facial redness
- ❒ Brown spots or freckles
- ❒ Age spots
- ❒ Red spots
- ❒ Scars(acne or surgical)
- ❒ Rash
- ❒ Non Surgical Tightening & lifting
- ❒ Fat Reduction
- ❒ Cellulite Treatment / Stretch Marks
- ❒ Customized Facials
- ❒ Treatment for Expectant & Nursing Moms
- ❒ Red Carpet Ready Treatments
- ❒ Tired looking
- ❒ Facial contouring
- ❒ Neck wrinkles
- ❒ Lines around mouth and nose
- ❒ Frown lines between brows
- ❒ Sagging skin
- ❒ Thin lips
- ❒ Drooping eyelids/brows
- ❒ Nose shape or size
- ❒ Dark circles/puffiness
- ❒ Facial veins
- ❒ Blue/red leg veins
- ❒ Hand rejuvenation
- ❒ Liquid Facelift
- ❒ Botox/Dysport/Xeomin
- ❒ Restylane • Restylane Silk • Restylane Lyft
- ❒ VOLUMA • Juvederm • Ultra Plus
- ❒ KYBELLA (Treatment for Double Chin)
- ❒ Radiesse
- ❒ Sculptra
- ❒ Boletero
- ❒ Ultherapy
- ❒ Fraxel DUAL
- ❒ Laser Genesis
- ❒ MicroPen
- ❒ Dermasweep
- ❒ Rezenerate (Zen) Pen
- ❒ Cellfina
- ❒ CoolSculpting
- ❒ Vanquish
- ❒ EXILIS
- ❒ UltraShape
- ❒ Pellefirm
- ❒ Z-Wave
- ❒ Pelleve
- ❒ Chemical Peels
- ❒ Laser Hair Removal
- ❒ Other not listed

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PATIENT INFORMATION

Date _____

PATIENT INFORMATION

Driver License Number: (REQUIRED- Of responsible party in case of minor) _____

Name: Last_____First_____Middle_____

Address_____ City, State, Zip_____

Phone: Home_____Work_____Ext_____

Cell Phone_____Email_____

Social Security# (REQUIRED)_____Birthdate_____

Sex: M F Martial Status: ❒ Single ❒ Married ❒ Widow ❒ Divorced ☐ Separated

Occupation_____ Employer_____

Address_____ City, State, Zip_____

How did you hear about us?_____ Referred by_____

Your Physician _____ Phone #_____

Your Pharmacy_____ Phone #_____

Emergency Contact_____ Phone #_____

PRIMARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company:_____ ID#_____Group_____

Policy Holder's Name:_____Birth date of Subscriber:_____

Policy Holder's Soc. Sec. #:_____

Claim Mailing Address _____

Relation to patient: ❒ SELF ❒ SPOUSE ❒ DEPENDENT

SECONDARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company:_____ ID#_____ Group_____

Policy Holder's Name:_____Birth date of Subscriber:_____

Policy Holder's Soc. Sec. #:_____

Claim Mailing Address_____

Relation to patient: ❒ SELF ❒ SPOUSE ❒ DEPENDENT

❒ I authorize the release my records to any referring physician or appropriate insurance company and medical information acquired in the course of my examination or treatment.

I agree to pay a cancellation fee of $50 for a medical appointment and $100 for a cosmetic appointment if I do not keep my appointment or if I cancel with less than 24 hours notice.

Signature of Patient or Responsible Party:_____

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OFFICE POLICY

All patients must complete our Patient Information sheet before having their appointment and/or procedure.

_____ **Regarding medication refills:**
It is your responsibility to ask your provider for any prescription refills needed at the time of your appointment. If you need medication refills between appointments, contact your pharmacy to see if there are refills remaining on your prescription. If no refills remain, have the pharmacy fax the request to our office at 210-692-3056 (fax). Many medications are not covered by insurance companies - ask your insurance provider for a list of medications not covered under your plan.

_____ **Confirming / Cancelling Appointments:**
You will receive a text and/or email reminder regarding appointments. **Please confirm or cancel your appointment by responding to this email/text or calling our office at (210) 692-3000.**

_____ **Regarding insurance with whom we participate:**
You are responsible to supply our staff with your ID cards. We will automatically file the claim for you if we accept your health insurance plan, however, you are responsible for any deductible or co-pay due at the time of service. If any of the procedures performed here are not a covered item under your plan, you be financially responsible for payment in full.

_____ **Regarding insurance with whom we do not participate:**
It is your responsibility to understand with which insurance plans Vivian W. Bucay, MD, PLLC participates. If we do not accept your health insurance, the bill is your responsibility and payment in full is due at the time of service. **Your health insurance policy is a contract between you and your insurance company, and it is your sole responsibility to understand its terms and conditions, this includes all prescribed medications.** Because Vivian W. Bucay, MD, PLLC does not participate with your health insurance company, we do not have a contract with your insurer. We are happy to give you a copy of your bill so you can file directly with your health insurance company. Understand that the ultimate responsibility for payment remains yours.

_____ **Regarding Medicare and supplementary insurance:**
We will automatically file your claim directly with Medicare and any other supplementary secondary insurance, if applicable. However, you remain responsible for your yearly deductible as well as any remaining co-payment.

_____ **Regarding laboratories:**
It is your responsibility to understand with which laboratory your insurance company affiliates. We are not liable for any services rendered to you by a laboratory that does not participate with your health insurance company.

_____ **Payments:**
We accept cash, check, money order, Visa, American Express, Master Card and Discover. There is a $50.00 fee for any returned check. **WE DO NOT BILL**. If this account is referred to a collection agency for nonpayment, there will be an **additional 30%** fee added to the outstanding balance.

❒ **I certify that I have read this form and fully understand its contents. I also acknowledge that no guarantees have been made to me as to the results of examinations of treatment.**

_____ _____
Patient Signature or Responsible Party (or Guardian) Date

_____
Printed Name of Patient

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PATIENT PAYMENT OBLIGATIONS

WELCOME TO THE PRACTICE OF VIVIAN W. BUCAY, MD, PLLC

1. Vivian W. Bucay, MD, PLLC requires that payment is due at the time of service. WE DO NOT BILL FOR SERVICES. We accept all major credit cards (and debit cards), checks and cash. If you plan to pay by check, the funds must be in the account and checks cannot be post-dated. You must also be able to provide your driver's license number.
2. It is also important to note that health insurance does not pay for cosmetic procedures. We offer ***Care Credit*** as a financing option for cosmetic procedures.
3. I hereby guarantee payment in full to Vivian W. Bucay, MD, PLLC for all charges for services rendered and/or charges exceeding third-party payments (except when prohibited by law or under contract). I also authorize Vivian W. Bucay, MD, PLLC to release all necessary information to government agencies, insurance carriers and others (including independent utilization review organizations) that are financially liable for the services in order to pre-authorize services, determine or challenge medical necessity, and to determine the extent and/or amount of liability. I hereby assign all amounts payable for services rendered to Vivian W. Bucay, MD, PLLC. I understand that this constitutes a waiver of confidentiality that is revocable, unless action has been taken in reliance thereon, and will otherwise remain in force indefinitely in order to effectuate the purposes for which it is given.

Thank you for reading our Financial Policy. Please feel free to let our billing office know if you have any questions or concerns by calling 210-692-3000.

Accepted and Agreed to: Date_____

_____ _____
Patient Signature or Responsible Party (or Guardian) Printed Name of Patient

CREDIT CARD AUTHORIZATION

As you know, if you have ever made an appointment/reservation with a salon, hotel or car rental agency, the first thing you are asked for is a credit card to pay your bill. This is an advantage for everyone because it makes checkout easier, faster, and more efficient.

We are implementing a similar policy. You will be asked for a credit card number at the time you check in and the information will be held in strict confidence. Once we are notified how much you are responsible after your insurance(s) has paid its portion for your treatment, any remaining balance you owe will be charged to your credit card and a copy of the charge will be mailed to your address. Additionally, in the event you are delinquent in timely paying an overdue balance, we reserve the right to charge that amount on your credit card as well. We also request that you provide us with updated credit card information anytime that it is warranted (card expires etc.).

Handling small balances in this manner is advantageous to you because it will eliminate the necessity to write out (small) check(s). It will also decrease the number of billing statements that we have to generate and mail to you, decreasing our costs.

This in no way will compromise your ability to dispute a charge or question your insurance company's payment determination. Co-pays remain due at the time of the visit. If you have a question for us, you may call the office or our billers at 210-521-6555.

Sincerely,
Vivian W. Bucay, MD, PLLC

❒ I accept and agree that **Vivian W. Bucay, MD, PLLC** can charge outstanding balances on my account for medical services of less than $100.^{00}$ to the credit card below. In case of amounts exceeding $100.^{00}$, we will call you and notify you of the balance. I acknowledge that I have had an opportunity to ask questions about this process.

Credit Card Type: ❒ Amex ❒ Mastercard ❒ Visa ❒ Other: _____

Account Number: _____ Expiration Date: Month:_____/ Year:_____CVC_____

Name on card: _____

Signature of cardholder: _____

Patient Signature: _____ ***Date:*** _____

To be signed at the appointment time

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PATIENT RELEASE AND CONSENT FOR TREATMENT

___ Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on services/procedures to the skin, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, or use of topical and/or oral prescription medications.

_____ I understand there are no guarantees as to the results of treatment/procedures to the skin, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, home follow-up care, etc.

_____ I understand that to achieve maximum results, I may need multiple treatments.

_____ I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the physician/clinician who performed the treatment.

_____ _____

Patient Signature Date

_____

Patient - Please Print Name

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,_____, understand that as part of my health care, Vivian W. Bucay, MD, PLLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Vivian W. Bucay, MD, PLLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Vivian W. Bucay, MD, PLLC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Vivian W. Bucay, MD, PLLC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Signature :_____ Date :_____