

326 W. CRAIG PLACE
SAN ANTONIO, TX 78212
210.692.3000



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 _____	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
Melanoma _____	Ulcers	Y N	HIV +/-AIDS	Y N
	Hypertension	Y N	Risk Factors for HIV	Y N
Unusual Moles _____	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.

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

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: _____

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



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



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



**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 : _____