bodyaesthetic
plastic surgery & skincare center

Thank you for calling Body Aesthetic Plastic Surgery & Skincare Center regarding your interest in enhancing your appearance. We welcome you as a new patient. Please know that our new patient appointments last from 60 to 90 minutes. Our consultations are designed to provide you with one on one time to meet Dr. Boswell and talk about what your needs are. He will discuss all the options of plastic surgery with you to make you feel and look the way you want to.

PLEASE have all forms completed prior to your appointment on _____. Some questions may require you to look up information about the health history of you and your family. Searching these health records at home will allow you to provide us with the most accurate information. Having your most complete and accurate health history will help us better ensure the safety of your treatment. Please include a list of prescription and over the counter medications that you currently take.

We collect a $99.00 consultation fee because we schedule an hour for your consultation with Dr. Boswell. This fee will be applied to your insurance copay or deductible, future cosmetic surgery, or injection treatment on the day of your appointment. *We do require a credit or debit card to hold the appointment. We do require a 24 hour notice to cancel or reschedule your appointment to avoid additional fees.* Our goal is to offer the best possible care to our current patients as well as accommodating new patients.

At Body Aesthetic Plastic Surgery we are committed to providing exemplary service to our patients. In order to make your first visit to our office smooth, we would like to provide some basic information:

1. **We pride ourselves in being on time for our appointments**. To continue to do so, we need the help of our patients. Please arrive 15 minutes early with your forms completed so that we may finalize your registration and take care of any last-minute details prior to your appointment. If you must complete your paperwork in the office, please arrive 30 minutes early if you need to complete office forms to allow ample time to complete your registration.

2. Please remember to bring your insurance card(s) even if you have scheduled a cosmetic consultation; some prescriptions require a pre-authorization call to your insurance carrier. If you have an HMO insurance plan, you must have a referral from your Primary care physician. Payment or co-payment for services rendered is expected at time of service.

Please do not hesitate to call our office at 314.628.8200 if you have any questions or if we may be of assistance to you. Our goal is to provide you with exemplary service and the best possible medical care. Again, thank you for calling our office; we look forward to meeting you. Please visit our website for more information: at: www.bodyaesthetic.com.

Sincerely,

Dr. C.B. Boswell and the staff of Body Aesthetic Plastic Surgery & Skincare

969 North Mason Road, Suite 170 ▪ St. Louis, Missouri 63141
314-628-8200 phone ▪ 314-628-9504 fax

Our Financial Policy

Thank you for choosing BodyAesthetic Plastic Surgery and Skin Care Center as your health care specialist. We are committed to your treatment being successful.
FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS, DEBIT CARDS, VISA/MASTERCARD, AND AMERICAN EXPRESS CARDS. PLEASE BE SURE TO HAVE ONE OF THESE FORMS OF PAYMENT WITH YOU AT THE TIME OF YOUR OFFICE VISIT. IF YOU DO NOT HAVE A FORM OF PAYMENT ON YOUR PERSON AT YOUR VISIT, WE WOULD BE HAPPY TO RE-SCHEDULE YOUR APPOINTMENT.

Payment Policy:

At the time of service, we will determine the portion of the bill for which you will be responsible. Prior to leaving, you will be responsible for paying your portion of the charge or pre-authorizing BodyAesthetic Plastic Surgery to charge your debit card or major credit card for the portion not covered by insurance. All self-pay patients are required to pay at the time of service

Co-pays:

You are expected to pay your copay at the time of service.

OUT OF POCKET AND/OR HIGH DEDUCTIBLE HEALTHPLANS(HDHP):

If your out of pocket or deductible is not met, you should anticipate paying for charges in full up to the deductible and/or out of pocket amount at the time of service.

Cosmetic Procedures

Cosmetic procedures are defined as procedures whose goal it is to enhance normal appearance or reverse the visible signs of aging. Your physician is the final arbiter of what constitutes a cosmetic procedure. The charges for cosmetic surgery are composed of a surgeon's fee, anesthesia fee, facility fee, room rate, nursing fee. Follow-up office visits related to this procedure are included in the surgeon's fee. Additional costs related to services from the facility, other physicians (for example: pathology/pathologist services), and additional surgery which may be required would be your responsibility. We also require cosmetic patients to provide us with medical insurance information to have on file in the event medical treatment is required. A nonrefundable scheduling fee is required to schedule surgery. The surgeon's fee is due as follows: **One-half of the total surgeon's fee is due one month prior to surgery date and the balance is due two weeks prior to surgery for all cosmetic procedures.** After this time, no personal checks will be accepted, and payment will need to be made by cash, cashier's check, credit card, debit card or bank transfer of funds.

Refunds/Cancellation

Cancellation of your surgery after it has been scheduled will result in loss of your scheduling fee. Cancellation within two weeks of the surgery date results in one-half of the surgeon's fee being retained by BodyAesthetic Plastic Surgery & Skincare Center. Written notice of cancellation of your contract within three days of when you scheduled surgery will incur no penalty.

Initial_____

Billing Questions

Questions or concerns regarding your account or insurance claim should be directed to our business manager. Our practice firmly believes that a good doctor-patient relationship is based upon understanding and good communication. We will make every effort to clarify any misunderstandings you have concerning your balance and resolve your financial questions and concerns. Please notify the business office immediately if you feel an error appears on the statement or if you have any questions or concerns.

Authorization of Benefits

1. **Authorization to Release Information**
   I hereby authorize the BodyAesthetic Plastic Surgery and Skincare Center to release information for processing of my medical claim.

2. **Authorization to Assign Benefits/Medicare Authorization**
   I hereby assign / transfer all title and rights of interest for services rendered to BodyAesthetic Plastic Surgery and Skincare Center.
   I hereby authorize the insurance company(s) to make payment directly to BodyAesthetic Plastic Surgery and Skincare Center for medical and surgical benefits otherwise payable to me. I hereby acknowledge that I am the subscriber, guarantor, and /or responsible party and therefore accept legal financial responsibility for all charges incurred. I agree to forward all insurance reimbursements directly to BodyAesthetic Plastic Surgery and Skincare Center upon receipt from my insurance carrier up to and including the full amount of the fees charged. In the event of non-payment, I acknowledge I will be responsible for any balances due including collection and legal fees associated with collection of said balance. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 30 days. In the event of a default, I promise to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effort collection of this note.
   I have read these terms and hereby assume responsibility for payment any charges according to these terms.

   I hereby authorize any holder of medical or other information about me to release to the Social Security Administrator or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of the authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

_____ _____

Date *Patient's Signature*

Initial_____

PATIENT REGISTRATION FOR BODYAESTHETIC PLASTIC SURGERY & SKINCARE CENTER

PLEASE PRINT

PATIENT'S FULL NAME (first, middle initial, last)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
HOME STREET ADDRESS	HOME CITY & STATE	HOME ZIP CODE
MOBILE PHONE NUMBER	HOME PHONE NUMBER	MARITAL STATUS
E-MAIL ADDRESS		RACE
PATIENT'S EMPLOYER	OCCUPATION	BUSINESS PHONE NUMBER
EMPLOYER'S ADDRESS (street, city, state, zip code)		EMPLOYMENT STATUS ☐ full time ☐ part time

HOW WOULD YOU PREFER CONTACT/REMINDER CALLS/TEXT FROM THE OFFICE: ☐HOME ☐ MOBILE ☐ EMAIL

MAY WE ADD YOUR EMAIL TO OUR MONTHLY UPDATES/SPECIALS? Yes ☐ No ☐

☐ SPOUSE OR PARENT'S NAME	SPOUSE/PARENT'S EMPLOYER
EMPLOYER'S ADDRESS (street, city, state, zip code)	PHONE NUMBER

PERSON RESPONSIBLE FOR PAYMENT (if it is not the patient)	RELATIONSHIP (parent, work comp)	PHONE NUMBER
ADDRESS (street, city, state, zip code)		

EMERGENCY CONTACT (name of friend or relative not living with you)	RELATIONSHIP	PHONE NUMBER
ADDRESS (street, city, state, zip code)		

Reason for visit _____ Date of injury _____ Work related Yes ☐ No ☐

How did you find out about us? _____

REFERRING PHYSICIAN:_____ Phone #_____

Address_____

Do you want this physician to receive reports? Yes ☐ No ☐ [For HMO insurance, we are required to send reports to your primary care physician.]

PRIMARY CARE PHYSICIAN: _____ Phone #_____
(If different from referring physician)

Do you want this physician to receive reports? Yes ☐ No ☐ [For HMO insurance, we are required to send reports to your primary care physician.]

PRIMARY INSURANCE CO. _____ Phone #_____

Address (street, city, state & zip code) _____

Subscriber Name_____ Subscriber Date of Birth _____

Subscriber SS/ID #_____ Group #_____ Policy/Certificate #_____

SECONDARY INSURANCE CO. _____ Phone #_____

Address (street, city, state & zip code) _____

Subscriber Name_____ Subscriber Date of Birth _____

Subscriber SS/ID #_____ Group #_____ Policy/Certificate #_____

Signature_____ Date_____

BODYAESTHETIC PLASTIC SURGERY

(314) 628-8200
969 North Mason Road Suite 170, St. Louis, MO 63141

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient Name:			
DOB	Age	Marital Status	Weight _____ lbs
What surgery are you considering?			Height ft in

DO YOU NOW OR HAVE YOU EVER HAD…….. (You must circle an answer for each individual item)

Heart Trouble	Yes	No	Glaucoma or Eye Problems	Yes	No
Heart Attack	Yes	No	Visual Disturbances	Yes	No
Heart Pain	Yes	No	Error in Refraction	Yes	No
Palpitation or Irregular Pulse	Yes	No	Other Eye Problems	Yes	No
Extra Heart Beats	Yes	No	Hepatitis	Yes	No
Stroke	Yes	No	Yellow Jaundice	Yes	No
Hypertension	Yes	No	Gallstones or Gallbladder Trouble	Yes	No
Blood Pressure Abnormalities	Yes	No	Cirrhosis of the Liver	Yes	No
Abnormal EKG	Yes	No	Alcoholism or Drug Dependency	Yes	No
Rheumatic Fever	Yes	No	Esophageal Varices	Yes	No
Dropsy or Heart Failure	Yes	No	Frequent Indigestion	Yes	No
Digitalis Treatment	Yes	No	Ulcers	Yes	No
Shortness of Breath	Yes	No	Gastritis	Yes	No
Chest Pain	Yes	No	Colitis	Yes	No
Asthma	Yes	No	Problem Constipation	Yes	No
Bronchitis	Yes	No	Vomiting Blood	Yes	No
Deep vein thrombosis or blood clots	Yes	No	Diarrhea	Yes	No
Pneumonia	Yes	No	Tarry or Bloody Bowel Movements	Yes	No
Tuberculosis	Yes	No	Hemorrhoids	Yes	No
Smokers Cough	Yes	No	Goiter or Thyroid Disorders	Yes	No
Emphysema	Yes	No	Diabetes	Yes	No
Coughing or Spitting of Blood	Yes	No	Skin Disorders	Yes	No
Hay Fever	Yes	No	Arthritis	Yes	No
Major Allergies	Yes	No	Fracture of Neck or Spine	Yes	No
Palsy or Paralysis	Yes	No	Bleeding Tendency or Disorder	Yes	No
Nervous Breakdown	Yes	No	Abnormal Bleeding after Tooth Extraction	Yes	No
Nervous Disorder	Yes	No	Airway Obstruction (Nasal)	Yes	No
Insomnia	Yes	No	Breast Cysts, Tumors, Abscesses	Yes	No
Drug Habit	Yes	No	Nipple Discharge (Apart from Normal Lactation)	Yes	No
Self-Destructive Tendencies	Yes	No	Kidney Disorder	Yes	No
Psychiatric Hospitalization or Care	Yes	No	Blood Transfusion	Yes	No
Thyroid Problems	Yes	No	Seizures or convulsions or fainting spells	Yes	No
Kidney or Renal Disease	Yes	No	Black outs	Yes	No
Heart murmur	Yes	No	Dentures, bridges, capped teeth or crowns	Yes	No
Piercing other than the ears	Yes	No	Loose teeth	Yes	No
Positive blood test for: HIV, AIDS, Hepatitis	Yes	No	Cosmetic bonding to teeth	Yes	No
Missed or irregular last menstrual period	Yes	No	Any family members with bleeding problems	Yes	No
Family history of cancer, heart trouble, stroke	Yes	No	Any family members with anesthesia problems	Yes	No
Have you or a family member had a blood clot?	Yes	No	Have you or a family member ever been on blood thinners?	Yes	No
Have you or a family member ever been diagnosed with a blood clotting disorder?	Yes	No	Do you or a family member bruise easily and often?	Yes	No
Have you ever been diagnosed with lupus or any other autoimmune disease?	Yes	No	Have you ever had a miscarriage?	Yes	No

1. **Please list all present medications**, including birth control pills, hormones, and vitamins, herbal medication, diuretics, weight loss drugs. **Include over-the-counter medications.**

_____

_____

_____

2. **Do you have an allergic reaction to any medication? ❒ Yes ❒ No Which? _____**

3. **Do you have a Latex allergy? ❒ Yes ❒ No**

4. Do you react abnormally to any medication? ❒ Yes ❒ No Which? _____

5. Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for anesthesia?

   ❒ Yes ❒ No If yes, when and where? _____

6. Have you or a member of your family had a MRSA (antibiotic-resistant staph) infection? ❒ Yes ❒ No If so, who and when?
   _____

7. Have you ever been on cortisone or steroid treatment? ❒ Yes ❒ No When? _____

8. Do you have cocktails regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol?

   ❒ Yes ❒ No If so, how much? _____

9. Have you ever smoked? ❒ Yes ❒ No If so, how much? _____ For how long? _____

   If you quit smoking, when did you quit? _____

10. Are you pregnant? ❒ Yes ❒ No When was you last normal menstrual period? _____

11. How many pregnancies? _____ Births? _____ How many children did you breast feed? _____ For how long? _____

    CHILDREN (list names and ages/birthdays): _____

    _____

12. When was your last physical exam? _____ By whom? _____

13. When was your last eye examination? _____ By whom? _____

14. When and where was your last chest x-ray? _____ EKG? _____

15. When and where was your last mammogram? _____

16. Who is your personal physician, if any? _____Please list all physicians presently caring for you.

    _____

    _____

17. Have you ever been under psychiatric care? ❒ Yes ❒ No When? _____Why? _____

18. Have you had any recent blood work done? ❒ Yes ❒ No Where? _____

19. Do you wear acrylic nails? ❒ Yes ❒ No Do you have them on currently? ❒ Yes ❒ No

20. Is there anything else you think the doctor should know? _____

_____

21. How did you hear about us? _____

22. Who may we thank for referring you to us? _____

23. Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

SURGICAL OPERATIONS (include where, when and why for each surgery): _____

_____

_____

HOSPITALIZATIONS (include where, when and why for each admission): _____

_____

_____

By signing below, I agree that the above information is complete and accurate to the best of my knowledge.

Signature: _____ Date:_____