OFFICE AND FINANCIAL POLICIES

We would like to thank you for choosing OCULUS for you aesthetic needs. As one of our clients, we would like to keep you informed of the current office and financial policies.

Insurance: OCULUS does **NOT** participate or submit billing for any private insurance companies.

Appointments: Missed appointments represent a cost to us, to you and to other clients who could have been seen at the time set aside for you. We require a 24 hour notice for canceling or rescheduling of any appointments. **There is a charge of $50.00 for missed or late canceled appointments.** Excessive abuse of scheduled appointments may result in discharge from the practice.

Payment: ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE; however, some services may require a deposit in advance, Oculus only accepts payment in the form of cash, check, VISA, MasterCard, American Express, Discover, Care Credit and Flex Spending Accounts.

Refund Policy: ALL SALES ARE FINAL. Before a service is performed please consider all the required protocols and side effects. We are committed to client satisfaction and are available to answer any questions or concerns you may have in regards to the services we offer before purchase. OCULUS may provide patients with prescription medication and if so are subjected to state and federal laws. These laws do not permit us to restock sold items and accept returned prescription medication for refund.

I have read, understand and agree to the office and financial policies set forth by OCULUS Medical Spa.

Patient or Guardian Signature_____**Date**_____

Patient Name(Please Print)_____

I agree to pay $_____IN FULL for services by

_____Credit _____Cash/Check _____CareCredit

Other arrangements made by _____ on todays date_____.

Services as described:_____

Total:_____ Amount Down_____

Balance Due:_____

(updated 2(2019)

SELF ASSESSMENT FORM

Please complete this questionnaire to help us better understand your history, preferences, and concerns with respect to aesthetic treatments and procedures. These responses will help us formulate the most personalized medical consultation and care plan for you.

How did you hear about OCULUS Medical Spa?
Have you had any aesthetic treatments or procedures in the past?

Previous Procedures: (*Please give last date of treatment*)
CO2_____ Erbium_____ Dermabrasion_____ Chemical Peels:Phenol_____TCA_____
Glycolic_____ Salicylic_____

Facial or Plastic Surgery_____

Other Treatments:_____

Areas of Concern:*(Please circle all that apply)*

Fine Lines/Wrinkles Lip Lines Volume Loss Skin Elasticity Sagging Skin
Hyperpigmentation/Age Spots Acne/Scars Facial Capillaries Skin Texture
Skin Disorder Color/Tone Skin Texture Brow/Lash

Home Skin Care Products:
Cleanser:_____ Frequency:_____ Toner/Astringent:_____
Moisturizer:_____ Eye Cream:_____
Exfoliator:_____ Sunscreen:_____
Other:_____ Makeup:_____

Other Services you may be interested in: *(Please circle all that apply)*

CoolSculpting	Vampire Facials	Microneedling
Botox	Laser Hair Removal	Microdermabrasion
Dermaplane	Acne Treatments	Skin Tightening
Salt Facial	FotoFacial	Brow and Lash Dying
Dermal fillers	Restylane/Kybella	Facial Peels

Client Name: _____ Date:_____

OCULUS
medical spa

MEDICAL HISTORY

Name:_____ **Date:**_____ **[ ] M [ ] F**

Address:_____
Street City State Zip

Home Phone:_____**CellPhone:**_____

Email:_____**Date of Birth:**_____

Brilliant Distinction Member Number:_____

How did you hear about us? Google Facebook Yelp Instagram Internet Other

Referred by: _____

Have you ever been treated for: (Check ALL that apply)

	Yes	No		Yes	No
High blood pressure	[ ]	[ ]	Liver disease	[ ]	[ ]
Heart problems or stroke	[ ]	[ ]	Cancer	[ ]	[ ]
Angina	[ ]	[ ]	Varicose veins	[ ]	[ ]
Shortness of breath	[ ]	[ ]	Anemia	[ ]	[ ]
Pulmonary embolism	[ ]	[ ]	Asthma/bronchitis	[ ]	[ ]
Migraine headaches	[ ]	[ ]	Fever blisters/Cold Sores	[ ]	[ ]
Hemophilia	[ ]	[ ]	Blood transfusions	[ ]	[ ]
Stomach problems	[ ]	[ ]	Yellow Jaundice	[ ]	[ ]
Arthritis	[ ]	[ ]	Hepatitis	[ ]	[ ]
Bells Palsy	[ ]	[ ]	Glaucoma	[ ]	[ ]
Epilepsy	[ ]	[ ]	Facial nerve damage	[ ]	[ ]
HIV	[ ]	[ ]	Glasses Contacts	[ ]	[ ]
Diabetes	[ ]	[ ]	Mitral valve prolapse	[ ]	[ ]
Depression	[ ]	[ ]	Mental conditions	[ ]	[ ]

Have you ever taken Accutane? Yes No

Current Medications:_____

Allergies:_____

Are you currently pregnant or breastfeeding?_____

Patient Signature or Guardian_____***Date***_____

(updated 2(2019)