



Carolina Family Medicine and Dermatology, PA/
 Carolina Laser and Cosmetic Center
 Anne L. White, M.D.
 3000 Bethesda Place Suite 601 & 602
 Winston-Salem, NC 27103
 336-659-2663 1-877-WE BOTOX

COSMETIC PATIENT INFORMATION
 Please complete all forms and sign where requested

Name: _____
 Last First Middle

Address: _____
 Street City State Zip

Date of Birth: ___/___/___ Age: _____ Male Female Marital Status: W M D S

Social Security Number ___-___-_____

Email Address: _____
 (This is important for appointment reminder / verification and/or special product offers)

For News letter sign up please check yes or no. yes: _____ no: _____

Home Phone: (____)____-_____ Business Phone: (____)____-_____

Employer: _____ Address: _____

Spouse's Name: _____ Spouse's SSN: _____-____-_____

Emergency Contact: _____ Phone Number: (____)____-_____

Relationship: _____

How did you hear about Carolina Laser and Cosmetic Center? Please check all sources:

Radio: WSJS 600AM____ WSMW Simon 98.7FM____ Television: WXII____

Newspaper : WS Journal____ WS Monthly:____ Friend/Colleague Recommendation? _____

Internet: Did you search for Carolina Laser?_____ for a procedure?_____ which? _____

Search Engine Used: Google____ Yahoo____ Bing____ Other_____

What service are you here for today? _____

Would you like information about any of the following services? Please circle:

Fillers and Injectables: Botox, Xeomin, Restylane, Radiesse, Dysport

Laser treatments: SmartLipo, Tattoo Removal, Hair Removal, Limelight Photofacial, Laser Toning, Skin Resurfacing, Microdemabrasion

Cosmetic and Medical: Ultherapy Lift, Latisse, Chemical Peel, Sclerotherapy, Skin Care

Would a Saturday appointment be more suitable to your schedule? _____

All cosmetic fees and deposits are NON-REFUNDABLE.

Authorization for payment to Carolina Laser and Cosmetic Center: I understand that it is my responsibility to pay all charges when services are rendered. Payments are non-refundable.

Authorization to release information: I hereby authorize the physician to release any medical information acquired in the course of my examination/treatment to specific insurance carriers, third party payors and others involved in processing and collection of this claim.

Patient Initials _____ Date _____

Anne L. White, M.D.
Carolina Laser and Cosmetic Center

Our "Full Disclosure" Credit Policy

Please read before signing If you have any questions please ask our staff. They will be happy to explain and clarify any of the following information.

All payments are due at the time of service rendered. If for any reason, full payment cannot be made at that time, payment arrangements must be made before leaving the office. For your convenience we also take MasterCard and Visa. You will be responsible for payments on the day of service.

Unpaid balances will be referred to a collection service and will affect your credit rating. If your account is placed with our attorney, you will be responsible for any and all collection fees, usual attorney fees and any cost that this office incurs in attempting to resolve your account.

Finance charges are assessed on personal balances over 30 days old at the rate of 22% APR.

There is a \$50.00 charge for all skin care follow up visits.

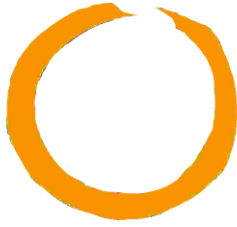
There is a **\$100.00** "No Show" or "DNKA", (Did Not Keep Appointment) fee without a **24-hour cancellation** notice.

If you are unable to come to the office, and for your convenience, we offer telephone consultations. We charge \$300/hour telephone consultation fee if you request a telephone consultation with Dr. White during office hours (\$75 per every 15 increments), and \$400/hour after hours (\$100 per every 15 increments). Please email photographs in advance of your consultation. Insurance will not pay for this and you will be responsible.

We welcome you as a patient, and are anxious for you to understand your bill and responsibilities. We will be happy to explain any portion of it to you at any time.

We are committed to providing excellent customer service. If you have a complaint, we want to hear it. Our goal is to continually improve the service we provide for our patients. We outsource our billing to a third party billing company, and are not always made privy to patient questions and concerns. If you have questions or concerns that you feel are not adequately addressed by our billing company, we ask that you discuss your concerns with Dr. White directly. Dr. White holds her staff to a high standard of performance. If you feel at any time that our staff does not meet your needs, please discuss your concern with Dr. White personally. Dr. White wants to hear from you.

Patient Initials _____ Date _____



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**ACKNOWLEDGEMENT of REVIEW of PATIENT INFORMATION,
CREDIT POLICY, and PRIVACY NOTICE**

I acknowledge that I have reviewed the following
information regarding Patient Information, Credit Policy, and
Privacy Notice provided to me by Anne L. White, M.D.

Patient's Printed Name

Patient's Signature

Date

Witness Signature