LIMMER HAIR TRANSPLANT CENTER

Intake form

Name: _____ Date of Birth: _____

Interests (Check all that apply) □ Hair Transplant □ Medical Therapy □ Gathering Info

How did you hear about us? (Check all that apply) □ I am a previous patient- Approximate last year seen:_____

□ Dr. Referral (Please specify) _____

□ Patient Referral □ Hair Stylist or Barber □ Internet Search □ Other media: TV, Radio, Print

Who can we thank for the referral? _____

When did you first start noticing your hair loss? _____

How is your hair loss affecting you? _____

What is your ***current regime*** for your hair loss? (check any that apply)

□ Finasteride 1mg (Propecia) □ Finasteride 5 mg (Proscar) □ Dutasteride (Avodart) □ Minoxidil (Rogaine)

□ Biotin □ Viviscal □ Nutrafol □ Other(s): please list_____

Have you ***previously tried*** and discontinued any of these medications? **Yes** or **No**

Please list_____

What areas are your biggest concerns? List in order of importance (1 being MOST important and so on):

_____ Frontal Hairline
_____ Crown
_____ Sideburns
_____ Temples Receding
_____ General thinning over entire scalp
_____ Eyebrows
_____ Facial Hair
_____ Other: _____

Have you ever had a hair transplant procedure before? ☐ yes ☐ no
If yes, please provide details (when/where/how many grafts):_____

Medical History: List all medical conditions you are being treated for:

_____

_____

Medications: list ***all*** prescriptions, over-the-counter, supplements and vitamins you are taking:

_____

_____

Allergies: _____

Patient/ Guardian Signature_____ **Date**_____

Limmer Hair Transplant Center

6810 West Ave Suite A, San Antonio, TX 78213

Patient Information Record

_____ _____ _____
Last Name First Name MI

_____
Street Address

_____ _____ _____
City State Zip Code

_____ _____
Cell Phone Secondary Phone

_____ May we contact you by email? : yes ☐ no ☐
Email Address

_____ _____
Employed By Work Phone

_____ Male ☐ Female ☐ Transgender ☐
Birth Date

Single ☐ Married ☐

_____ Other ☐ _____
Spouse's Name

_____ _____
Spouse's Employer Spouse's Phone

_____ _____
Person Responsible for payment Relationship

_____ _____ _____
Emergency Contact – Relationship **Home Phone** **Work Phone**

I understand that payment is due at time of service. Dr. Krejci does not file claims with any insurance or Medicare. I may choose to submit claims myself for reimbursement to my insurer; however, I have been informed that hair loss is generally not covered. I authorize the release of any information pertinent to my case to my insurance company to process my claims or to any outside party that I so designate in a record release.

_____ _____
Signature of patient or legal guardian Date

Limmer Hair Transplant Center

6810 West Ave. Suite A, San Antonio, TX 78213

Our Policy Related to Payment for Medical Services

Dr. Jennifer Krejci is not a participating provider with any insurance companies, including Medicare and Medicaid. Medicare will NOT cover any hair restoration procedures or evaluations. Therefore, Hair Transplant procedures and all other evaluations and services for hair loss will not be billed to Medicare or other insurance.

You are expected to pay for any fees in full on the date of service.

Limmer Hair Transplant Center accepts Master card, Visa, Discover, and American Express.

Care Credit is accepted for procedures costing more than $1000. We offer 6 months with no interest or 24 months with interest. Care Credit cannot be used for making deposits towards a surgical procedure.
If you are interested in applying for Care Credit, please let us know.

Limmer Hair Transplant Center does not accept personal checks for hair transplants unless it is paid 3 weeks in advance.

Limmer Hair Transplant Center will ***only*** accept personal checks from patients living in San Antonio for office consultations and visits. **Please note:** There will be a $50.00 collection fee for checks that are returned.

There is a $50 charge for "no-show" appointments. If you need to cancel or reschedule any appointment, please call or email the office as soon as possible.

I, the undersigned, have read this policy and understand my responsibility for charges from the Limmer Hair Transplant Center.

_____ _____

Signature of patient or legal guardian Date

Limmer Hair Transplant Center

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Acknowledgement of HIPAA Form

I acknowledge I have read the HIPAA notice of Dr. Jennifer Krejci M.D.

Below are the names of family members and/or friends with whom it is permissible to share my Protected Healthcare Information (PHI). This authorization will stay in affect unless it is changed by me.

Names of Person(s) who may receive my medical information:

Name	Relationship	Phone Number

_____ _____

Signature of patient or legal guardian Date

_____

Printed name of patient

LIMMER HAIR TRANSPLANT CENTER

Photography Release

I hereby authorize Limmer Hair Transplant Center, hereafter referred to as “Company,” to publish photographs taken of me, for use in the Limmer Hair Transplant's print, online and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless Limmer Hair Transplant Center from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Limmer Hair Transplant Center, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization (check one)

☐ I authorize only photos that would be considered anonymous (e.g. top of the head with no distinguishing facial features or birthmarks exposed).

☐ I authorize use of any photos including those with recognizable features including my eyes or face exposed.

☐ I DO NOT AUTHORIZE the use of any of my photos for publication or other use.

Patient Printed Name: _____

Patient Signature: _____ Date: _____