



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 | _____ General thinning over entire scalp |
| _____ Crown | _____ Eyebrows |
| _____ Sideburns | _____ Facial Hair |
| _____ Temples Receding | _____ 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

Our Policy Related to Payment for Medical Services

Dr. Jennifer Krejci and Dr. Allison Limmer are not participating providers 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.

Consultation Fee Policy

The consultation fee may be applied toward the cost of a hair transplant procedure if the patient elects to schedule their procedure within seven (7) days of the consultation date. This policy is intended to provide patients with adequate time to make an informed decision while maintaining the value of the consultation.

If the procedure is scheduled more than seven (7) days after the consultation, the consultation fee will not be credited toward the procedure cost.

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 and PatientFi is accepted for procedures costing more than \$1000. We offer 6 months with no interest or up to 24 months with interest. Care Credit/PatientFi cannot be used for making deposits towards a surgical procedure.

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-shows” and cancellations within 24 hours of your 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
6810 West Ave. Suite A, San Antonio, TX 78213

Acknowledgement of HIPAA Form

I acknowledge I have read the HIPAA notice of Dr. Jennifer Krejci M.D. and Dr. Allison Limmer 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
<hr/>		
<hr/>		
<hr/>		
<hr/>		

Signature of patient or legal guardian

Date

Printed name of patient



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: _____