



**Diplomats of the American Board of Dermatology
General, Surgical and Cosmetic Dermatology**

Stephen Miller, MD
Karis McCarroll, MD
Brittany Lenz, MD
Lavonne Stumbaugh NP-C

Catherine Tisdall, MD
Scott Dalton, DO
Natalie Marshall, PA-C
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CREDIT/DEBIT CARD ON FILE AUTHORIZATION

You will be asked for a credit card at the time you check in and the information will be held securely. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will charge your card and a copy of the receipt will be emailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask.

Authorization

Until further notice, I authorize Dermatology San Antonio to charge the patient-responsible balances on my account to the following credit card until any balance on my account has been satisfied:

Circle one: Visa MasterCard Discover Amex

Last 4 digits of my credit card: _____ Exp. Date (mm/yy): _____

Please hand your credit card to the Receptionist when you check in. She will enter your card information into the secure credit card processing website. Thank you.

Signature: _____ Date: _____

Printed Name: _____

Email, if you would like an emailed receipt: _____

Note: The amount to be charged per month should not extend the payment process more than 5 months in the future, so the amount should be set to always account for no less than 20% of the account balance.

Informed Consent for Telemedicine/Telehealth Consultations

Telemedicine and Telehealth means that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- The consulting health care provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the Provider.
- I understand that my voice and image may be recorded in order to assist the medical or registration personnel and I consent to any such audio and video recording.
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.
- I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care.
- I understand that payment will be collected at the time of service and cannot be refunded once the consultation has begun.

Authorizations

- The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows: By typing my name below, I am granting permission to all physicians, laboratories, and any other professionals to perform and administer care and treatment of the patient, or designated other qualified health care provider for such services.
- Grants permission to release to third party payor(s), Medicare, their representatives and/or physician(s) involved in the patient's care, any information needed in connection with all care rendered to patient.
- If the patient is under the age of 18 or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.

Financial Responsibility

I and/or my insurance carrier(s) agree to pay, in a timely manner, for emergency health care services provided. I authorize payments directly to Dermatology San Antonio for all benefits payable. I understand that most private and government insurers do not include coverage for this service as a "Covered Service". I understand that I am responsible for any unpaid bills not covered by Medicare, and any other private insurance company(s).

Signature
Patient Name (PRINT):

Date

Signature of Person Obtaining Verbal Consent
Print Name:

Date

Signature of Person Witnessing Verbal Consent
Print Name:

Date



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Shavano Commons Business Park

Helotes Country Village

Westover Hills

Singing Hills

PATIENT REGISTRATION

Today's Date: ____ / ____ / ____ .

Patient Last Name: _____ First Name: _____ MI: _____

Address: _____ APT# _____ City: _____ State: ____ Zip code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: ____ - ____ - ____ DOB: ____ / ____ / ____ Email: _____ @ _____ . _____

Marital Status: Single Married Other Gender: Male Female Transgender

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

Employer: _____ Work Phone: _____

Race: White Asian African American Other: _____
Ethnicity: Not Hispanic Hispanic Other: _____ **Language:** English Spanish Other: _____
 Decline to Answer

Referring Physician: _____ Phone: _____ Clinic Name: _____

Pharmacy Name: _____ Phone: _____ Address: _____

Responsible Party Information (if different from patient)

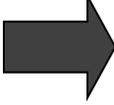
Who is the insured party? Self Spouse Mother Father Other _____

Primary Insured: _____ DOB: ____ / ____ / ____ SSN: ____ - ____ - ____

Insurance Co: _____ ID#: _____ Group #: _____

Secondary Insured: _____ DOB: ____ / ____ / ____ SSN: ____ - ____ - ____

Insurance Co: _____ ID#: _____ Group #: _____

 **PATIENT Signature:** _____ **Date:** _____
(OR IF patient is under 18 Parent/Legal Guardian's signature is required)



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Medical History

Patient Name: _____ DOB _____

Referring MD _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Do you have a Health Care Proxy, or would you like to name a surrogate decision maker? _____
(Yes/No/Decline)

If Yes, please provide details below:

Name:	
Relationship:	
Phone Number:	

Do you have an Advanced Care Directive? _____
(Yes/No/Decline)

If Yes, please provide details below:

DNR: Do not Resuscitate	
Full Cardiopulmonary Resuscitation	
Other:	

Current Medications & Supplements (If none, please print none)

Medication Name	Dosage	Medication Name	Dosage

Allergies (If none, please print none)

Allergy	Reaction	Allergy	Reaction

Patient Past Medical History

(Please check appropriate boxes)

No Pertinent Past Medical History		Hepatitis/HIV/Tuberculosis (TB)	
Antibiotics prior to routine dental procedures		High blood Pressure	
Asthma/COPD		Kidney Disorder	
Autoimmune Disorder/Lupus		Liver Disorder	
Bleeding Disorder		Neurologic disorder/MS/Dementia	
Blood Clot/DVT/Thrombophlebitis		Pacemaker/Defibrillator	
Cancer (other than skin cancer)		Radiation Therapy	
Depression/Psychiatric Disorder		Reflux/Peptic Ulcers/Crohn's/ Ulcerative Colitis	
Diabetes		Thyroid Disorder	
Heart Disease Murmur		Other History	

Skin History

(Please check appropriate Boxes)

No Significant Skin History		Other Suspicious Lesion(s)	
Actinic Keratosis		Eczema	
Basal Cell Carcinoma		Seasonal/Food Allergies	
Squamous Cell Carcinoma		Urticaria/Hives	
Malignant Melanoma		Autoimmune Disorder/Lupus	
Skin Cancer (Basal Cell/Squamous Cell Carcinoma)		Keloids	
Asthma		Abnormal Clotting/DVT	
Seasonal Food Allergies		Other Family History, please list:	

Past Surgical History

Name of Surgery: _____	Date of Surgery: _____
Name of Surgery: _____	Date of Surgery: _____

Social History

(Please check appropriate boxes)

Alcohol Consumption: None Socially Daily
<input type="checkbox"/> UV Exposure <input type="checkbox"/> Current Tanning bed use <input type="checkbox"/> Past tanning bed use <input type="checkbox"/> >5 Blistering sunburns
<input type="checkbox"/> Use Sunscreen
Smoking Status: <input type="checkbox"/> Current Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoked

If child: is growth and development appropriate: <input type="checkbox"/> Yes <input type="checkbox"/> No Vaccinations up to date: <input type="checkbox"/> Yes <input type="checkbox"/> No
--

Signature _____ Date _____

(Patient or Legal Guardian)



acc# _____

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Financial Policy

At Dermatology San Antonio, we believe that all patients who are rendered care at this office deserve the best medical care that can be provided. We provide you with the Agreement regarding our financial policy and your agreement to pay for services provided so that you are aware of our policies and procedures up front. We require each patient to sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS

We require that you pay any amount not covered by your insurance under your policy on the date of service. Dermatology San Antonio is required, in accordance with its contract with your insurer, to collect deductibles and copayments at the time of service. We will determine your copay and how much of your yearly deductible under your policy has been met for the year, if possible. If you are unable to pay your copayment at check-in, another appointment will be made for you. Account balances must have a monthly payment plan in place and any monthly payment not received by the date of your scheduled appointment will be required to be paid prior to seeing a provider. We will always work with you to arrange a payment plan.

We will request to see your current insurance card and photo identification so that we may verify insurance accurately. If a claim is rejected because your insurance does not cover the type of service rendered or if you provided us an expired insurance card, you will be held financially responsible for payment of services and any outstanding balance.

CREDIT CARD ON FILE

We require a credit or debit card on file with our office. We need to ensure that we have a guaranteed form of payment on file in our office.

We do not store your sensitive credit card information in our office. We store it in a secure fashion with a reputable financial firm called a Gateway which is handled by our merchant services vendor. We access your information only on this site to process a payment. You will be required to sign a credit card on file authorization statement that will allow us to charge an amount agreeable to each of us until your balance is paid in full.

We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier.

Once we determine your personal financial obligation or after your insurance company pays Dermatology San Antonio for a portion of your care, we will begin to process payments that were previously discussed and approved by you.

Any account past due by 30 days or more may be subject to submission to our collection agency. Dermatology San Antonio reserves the right to discharge, with proper notice, any patient for non-payment. By signing our financial policy, you agree to pay these added fees, along with any and all costs associated with the collection of your account.

If you carry a balance on your account during the time you present at our office, a payment on your account will be required at the time of service unless a prior payment plan has been set up. **Once we determine a payment is due, the patient will receive a call/email which information on balance due. Payment will be processed within 24 hours of the call/email.**

SUBMISSION OF CLAIMS

We will submit your insurance claims on your behalf to your insurance company. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services not covered by your insurance carrier.

PAYMENT OPTIONS

Our office accepts most credit and debit cards. Our office also accepts valid check or cash. There will be a \$50 fee for all returned checks. Once we have a returned check for you, we may require that all future payments be with cash, money order, cashier's check or credit card. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit or debit card.

ELECTIVE PROCEDURES/NON-COVERED PROCEDURES

Patients are required to pay the self-pay portion of elective/non-covered procedures prior to services being rendered.

CASH PAYMENT

If you wish to pay cash, you will always be provided a receipt so that you will have a record of your payment. Please make us aware if you are not provided a receipt at any visit.

NON-CONTRACTED INSURANCE (Out of Network)

If you have an insurance plan that we do not participate with, you may or may not have out of network benefits. You will be considered a self-pay, uninsured patient if you do not have out of network benefits and you are financially responsible.

MISSED APPOINTMENTS/NO SHOWS/CANCELLATIONS, LATE FOR APPOINTMENT

We understand that you may not be able to keep all of your scheduled appointments or might occasionally be late. Failure to cancel or reschedule a medical appointment at least 48 hours in advance will be considered a no-show. ***We reserve the right to charge you \$75.00 for this type of no-show appointment.*** Failure to cancel or reschedule an aesthetic appointment at least 48 hours in advance will be considered a no-show. ***We reserve the right to charge you \$50 for this type of no-show appointment.***

For any of the following elective surgical procedure or elective aesthetic procedure, including, but not limited to sclerotherapy, kybella, subcision, PRP injections, Microneedling, and Physician/Physician Assistance/Nurse Practitioner administered chemical peels or laser procedures, a \$250.00 deposit is required to schedule these types of appointments. **Failure to cancel or reschedule any of these types of appointments with at least 48 hours' notice will result in forfeiture of the \$250.00 deposit.** For CoolSculpting, QWO, Treads, Cooltone and Ultherapy a \$500.00 deposit is required to schedule these types of appointments. **Failure to cancel or reschedule any of these types of appointments with at least 48 hours' notice will result in forfeiture of the \$500.00 deposit. Failure to cancel or reschedule any** Excision of cysts, Lipomas and benign Nevi will result in a \$250.00 no show fee for private pay patients.

Dermatology San Antonio reserves the right to permanently discharge a patient with more than one no-show appointment with 30 days written notice to the patient to seek medical help from another practice.

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointments. If you are more than 15 minutes late for an appointment, Dermatology San Antonio may reschedule your appointment.

REFERRALS

If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that our office receives the current valid authorization. If you do not have a referral or authorization, we will be unable to treat you until a valid authorization/referral is obtained or full payment from you will be expected at the time of service. If you wish to pay in full, your insurance will not be billed.

FORMS AND MEDICAL RECORDS FEES

Copies of records for personal use or to be sent to another practice or facility, will be charged the allowed fee communicated by the Texas Medical Board and/or HIPPA regulations.

FMLA, Disability, Attorney Subpoenas, VA and MEPS/DOD \$40.00

Dictated letters, extensive forms with review of medical records \$15.00 per page

CONSENT TO TREATMENT

As a consenting adult and/or legal guardian, I agree to permit the physicians and staff at Dermatology San Antonio to provide medical care to myself, my child or the patient I represent, as applicable. By signing below, I agree to permit the physician and staff at Dermatology San Antonio to perform necessary or appropriate medical care including physical examination, diagnosis, photographing area of assessment and treatment. _____

CONSENTS

I consent to medical or cometic photographs be taken of me by DSA and/or staff. I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the medical care I receive. If I wish to withdraw my consent in the future, I may do so with a written request. I authorize the use of the following: For demonstration purposes including office photo albums. On our website, print advertising and/or professional journals and social media. _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans, to Dermatology San Antonio. I understand that I am responsible to follow up with the insurance plan due to any discrepancy in coverage. I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Dermatology San Antonio to release all information necessary to secure payment. _____

I have read the Authorization for Consent for Treatment, Release of Medical Records, and Assignment of Benefits.

Signature Date

Patient Name (PRINT): _____

Signature Date

Name of Responsible Party (PRINT): _____

“Notice of Privacy Practices”

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

-Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.

-Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

-Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

-The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible. We may also create and distribute de-identified health information by removing all reference to individually identifiable information. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us. The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

-Most uses and disclosure of psychotherapy notes;

Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;

-Disclosures that constitute a sale of PHI under HIPAA; and

-Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization. You may have the following rights with respect to your PHI:

-The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

-The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.

-The right to inspect and copy your PHI.

-The right to amend your PHI.

-The right to receive an accounting of disclosures of your PHI.

-The right to obtain a paper copy of this notice from us upon request.

-The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed. If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure. We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI. This notice is effective as of September 3, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office. You have recourse if you feel that your protections have been violated by our

office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint. Feel free to contact the Practice Compliance Officer, Letty Garnett, at 210-615-7171 ext. 205 for more information, in person or in writing.



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Receipt of Notice of Privacy Practices

I am a patient of Dermatology San Antonio; I hereby acknowledge receipt of Dermatology San Antonio's Notice of Privacy Practices.

Signature: _____
(Patient)

OR

I am a parent/Legal guardian of _____, and hereby acknowledge
(Patient)
receipt of Dermatology San Antonio's *Notice of Privacy Practices* with respect to the patient.

Print Name: _____ Relationship to patient: _____
(Guardian)

Signature: _____
(Guardian Signature)



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Authorization to Release Protected Healthcare Information to Designated Representative(s)

I, give my authorization to release my Protected Health Information, including records and results of my laboratory test, x-ray, or biopsy results to the following designated representative(s):

_____ My spouse (name) & phone number _____

_____ My child (name) & phone number _____

_____ Other (name) & phone number _____

_____ Personal Representative & phone number _____

_____ May be left on home answering machine (home number) _____

_____ May be left on my work answering machine (work number) _____

_____ May be left on my cell phone (cell number) _____

_____ May send an encrypted email _____

_____ MAY NOT BE GIVEN TO ANYONE OTHER THAN MYSELF

Signature: _____

Date: _____

As a patient, you have the right to revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Dermatology San Antonio must receive the revocation in writing.



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Shavano Commons Business Park

Helotes Country Village

Westover Hills

Authorization and Consent to Treat a Minor

Appointing a Guardian to Accompany a Minor During Treatment

I, _____ authorize and appoint _____, as my agent,
(Parent/Legal Guardian) (Person attending the visit)

for my minor child, _____, _____/_____/_____ to Dermatology San Antonio,
(Patient) (DOB)

for their medical visit. I understand the medical care may include any of the following:

Evaluation, diagnosis, treatment, and prescription medications

In addition, it is sometimes necessary to do procedures like; acne cyst injections, incision and drainage, cryo-therapy and biopsies.

I DO or DO NOT authorize and appoint the person named above to accompany and give consent for and to undergo procedures: acne cyst injections, incision and drainage, cryo-therapy and biopsies.

My authorization is continuous permission YES or NO. If **No**, please give specific date of visit ____/____/____

(Signature of Parent/Legal Guardian) _____/_____/_____
(Date)

Without A Parent/Guardian Present

I, _____ give permission for Dermatology San Antonio, its staff, doctors and providers to treat
(Parent/Legal Guardian)

_____/_____/_____, without a parent/ legal guardian being present in
(Patient) (DOB)

the clinic or patient room during the time of treatment. I understand the medical care may include any of the following:

Evaluation, diagnosis, treatment, and prescription medication.

I also understand that a biopsy **will not** be performed unless a parent/guardian or appointed adult **is** present in the room while the biopsy is being

performed.

I also understand that permission **does not** apply if the patient is **under the age of 16**.

Continuous permission ____ yes ____ no If no please give specific date of visit _____

(Signature of Parent/Legal Guardian) _____/_____/_____
(Date)



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Shavano Commons Business Park Helotes Country Village Westover Hills Comal County

Cosmetic and Aesthetic Services

Are you interested in learning more about products or procedures that will help you look and feel more youthful? YES NO
If yes, take the following survey to help us get to know your needs better. Are you interested in treatments for:

Wrinkles

- Around your eyes
- Around your mouth
- Forehead
- Between your brows

Brown Spots / Skin Texture

- Face
- Neck/chest
- Hands

Miscellaneous

- Acne scarring
- Dark circles under eyes
- Puffy eyes
- Stubby or short eye lashes

Veins

- Face
- Legs
- Other

Volume Loss

- Under eyes/Cheeks
- Jowls
- Lips
- Folds around the mouth

Excess Fat/Body Sculpting

- Love handles
- Belly fat
- Upper arms
- Saddle bags, Inner thighs
- Bra fat
- Double Chin

Unwanted Hair/ Hair Loss

- Face Scalp
- Body

Skin Tightening

- Face Chest
- Neck

ARE YOU INTERESTED IN ANY OF THE FOLLOWING?

(circle all that apply)

- | | |
|--------------------------------|------------------------------|
| • Medical Grade Skin Care | • Botox |
| • Laser Hair Removal | • Dysport |
| • Sclerotherapy (spider veins) | • Juvederm Family |
| • CoolTone | • Voluma |
| • Coolsculpting | • Sculptra Aesthetic |
| • Ultherapy | • Restylane Family |
| • Kybella | • Radiesse |
| • Chemical Peels | • CO2 Fractional Resurfacing |
| • Diamond Glow Dermalinfusion | • IPL/Photofacial |
| • PRP for hair loss | • Micro-Needling |
| • Acne Scar Treatment | |

Please visit www.dermसानantonio.com for more information about these anti-aging services.

Name: _____ DOB: _____ / _____ / _____

Email: _____ @ _____ . _____ Phone: _____ - _____ - _____