Hobdari Family Health
*Lindita R. Hobdari M.D.*

1855 Veterans Park Drive, Suite 201
Naples, Florida, 34109
Phone: 239-260-1033 | Fax: 239-260-1491
www.HobdariHealth.com

# PATIENT INFORMATION

Thank you for choosing HOBDARI FAMILY HEALTH. In order to properly serve you, we need the following information.

## PATIENT INFORMATION

Name: (Last, First, MI) _____ Email: _____

Address: (Street) _____ (City, St, Zip) _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Social Sec#: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Place of Employment: _____ Occupation: _____

Employer's Address: _____

Extended Information: (Choose One) ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Parent's Name: _____ Relationship: _____

Spouse/Parent's Employer: _____ Work Phone: _____

Person to Contact in Case of Emergency: _____ Phone: _____

IF SEASONAL RESIDENT: 2nd Address _____

DATES AT 2ND ADDRESS: From _____ To _____

Guarantor/Responsible Party: (Person Responsible for Payment of Your Service if different from Patient)

Name: _____ Relationship to Patient: _____

Address (if different from Patient): _____

## INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____ SS# _____

Insurance Co: _____ Policy #: _____ Group #: _____

Choose One: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ No ☐ Yes If Yes, please complete the following:

Insurance Co: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____ ☐ Self ☐ Spouse ☐ Parent ☐ Other:

PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

I authorize the release of any medical or other information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services.

I give my permission to leave phone messages regarding my medical care/appointment confirmation: ☐ Yes ☐ No

☐ Check here if you prefer to be contacted by email.

Signed (Patient or Guardian) _____ Date _____

All bills are ultimately the responsibility of the patient. We will file insurance claims as noted, however, if your insurance has not paid in 60 days, the bill is due and payment by you is expected immediately.

# COMPREHENSIVE PATIENT HISTORY

**Please complete the following two pages.**

Patient Name: _____ Date of Birth: _____ Soc. Sec. #: _____

Occupation _____ List all previous occupations: _____

Birth place: _____ List all States/Countries visited: _____

What is the reason for today's visit? _____ Today's Date: _____

**Describe the following (if applicable):**

Location of problem: _____ How long have you had this problem? _____

How severe is this problem? ☐ Mild ☐ Moderate ☐ Very How often are you having the problem? _____

What caused the problem? _____

Do you know of anything else that may have contributed to this problem? _____

Does anything else occur with this problem? _____

When was your last complete physical examination? _____ Where? _____

## PERSONAL HISTORY:

| ILLNESSES: Have you ever had: | | | Heart disease | ☐ Yes | ☐ No |
|---|---|---|---|---|---|
| Measles | ☐ Yes | ☐ No | Meningitis | ☐ Yes | ☐ No |
| Chicken pox | ☐ Yes | ☐ No | Anemia/jaundice | ☐ Yes | ☐ No |
| Whooping cough | ☐ Yes | ☐ No | Migraine headaches | ☐ Yes | ☐ No |
| Scarlet fever | ☐ Yes | ☐ No | Diabetes or cancer | ☐ Yes | ☐ No |
| Pneumonia | ☐ Yes | ☐ No | Asthma/emphysem | ☐ Yes | ☐ No |

| INJURIES: Have you ever had: | | |
|---|---|---|
| Broken bones | ☐ Yes | ☐ No |
| Sprains/dislocations | ☐ Yes | ☐ No |
| Lacerations (extensive) | ☐ Yes | ☐ No |
| Concussion/head injury | ☐ Yes | ☐ No |
| Ever been knocked out | ☐ Yes | ☐ No |

SURGERY: List previous hospitalizations/serious injuries: When?

1 _____ _____
2 _____ _____
3 _____ _____
4 _____ _____
5 _____ _____

ALLERGIES: List any (food, drug, other):

1. _____
2. _____
3. _____
4. _____
5. _____

SOCIAL HISTORY:

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily: _____

Use of tobacco: ☐ Never ☐ Previously but quit ☐ Current packs per day: _____

Drug use: ☐ Never ☐ Type/Frequency: _____

Excessive exposure at home/work ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise

Caffeine use: How many cups coffee/tea/soda per day? _____

Regular exercise: How often? _____

MEDICATIONS: List all regularly taken:

1. _____
2. _____
3. _____
4. _____
5. _____

Do you get regular flu shots? ☐ Yes ☐ No

Last Tetanus _____

Last Pneumonia _____

| **FAMILY HISTORY** | | | Diabetes | ☐ Yes | ☐ No | High blood pressure | ☐ Yes | ☐ No |
|---|---|---|---|---|---|---|---|---|
| Cancer | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No | Heart trouble | ☐ Yes | ☐ No |
| Arthritis/Gout | ☐ Yes | ☐ No | Seizures | ☐ Yes | ☐ No | Bleeding Tendency | ☐ Yes | ☐ No |
| Acute Infections | ☐ Yes | ☐ No | Venereal Disease | ☐ Yes | ☐ No | Hereditary Defects | ☐ Yes | ☐ No |
| Tuberculosis | ☐ Yes | ☐ No | Asthma/emphysem | ☐ Yes | ☐ No | HIV/AIDS | ☐ Yes | ☐ No |
| Epilepsy | ☐ Yes | ☐ No | Mental Illness | ☐ Yes | ☐ No | Congenital Deformities | ☐ Yes | ☐ No |

**Patient History Continued:**

| **FAMILY HISTORY:** | Age | Diseases | If Deceased, Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brother or Sister | | | |
| | | | |
| Spouse | | | |
| Children | | | |
| | | | |
| | | | |
| | | | |

**PLEASE ANSWER ALL QUESTIONS** ***Have you recently experienced any of the following?***

**GENERAL HEALTH & WELL-BEING**

| | | |
|---|---|---|
| Good general health lately | ☐ Yes | ☐ No |
| Recent weight change | ☐ Yes | ☐ No |
| Fever | ☐ Yes | ☐ No |
| Fatigue | ☐ Yes | ☐ No |
| Headaches | ☐ Yes | ☐ No |

**EYES**

| | | |
|---|---|---|
| Eye disease or injury | ☐ Yes | ☐ No |
| Wearing glasses/contact lens | ☐ Yes | ☐ No |
| Blurred or double vision | ☐ Yes | ☐ No |
| Glaucoma | ☐ Yes | ☐ No |

**EARS, NOSE, THROAT, SINUS**

| | | |
|---|---|---|
| Hearing loss | ☐ Yes | ☐ No |
| Ringing in the ears | ☐ Yes | ☐ No |
| Perforated (hole in) ear drums | ☐ Yes | ☐ No |
| Earaches or drainage | | |
| Sinus problems | ☐ Yes | ☐ No |
| Seasonal nasal discharge (allergies) | ☐ Yes | ☐ No |
| Loss of smell | ☐ Yes | ☐ No |
| Nose bleed | ☐ Yes | ☐ No |
| Mouth sores | ☐ Yes | ☐ No |
| Bleeding gums | ☐ Yes | ☐ No |
| Bad breath or bad taste | ☐ Yes | ☐ No |
| Sore throat or voice change | ☐ Yes | ☐ No |
| Swollen glands in neck | ☐ Yes | ☐ No |

**HEART & CIRCULATORY SYSTEM**

| | | |
|---|---|---|
| Heart trouble | ☐ Yes | ☐ No |
| Chest pains | ☐ Yes | ☐ No |
| Palpitations or flutter of heart | ☐ Yes | ☐ No |
| Swelling of feet, ankles or hands | ☐ Yes | ☐ No |
| Shortness of breath that awakens you at night | ☐ Yes | ☐ No |
| Cramping in legs | ☐ Yes | ☐ No |
| High blood pressure | ☐ Yes | ☐ No |

**LUNGS**

| | | |
|---|---|---|
| Frequent coughing | ☐ Yes | ☐ No |
| Spitting up blood | ☐ Yes | ☐ No |
| Shortness of breath | ☐ Yes | ☐ No |
| Asthma or wheezing | ☐ Yes | ☐ No |

**GENITOURINARY**

| | | |
|---|---|---|
| Frequent urination (voiding) | ☐ Yes | ☐ No |
| Burning or painful urination | ☐ Yes | ☐ No |
| Blood in urine or discoloration | ☐ Yes | ☐ No |
| Change in force or strain when urinating | ☐ Yes | ☐ No |
| Inability to control bladder or dribbling | ☐ Yes | ☐ No |
| Getting up at night to pass urine | ☐ Yes | ☐ No |
| Kidney stones | ☐ Yes | ☐ No |
| Male – testicle pain | ☐ Yes | ☐ No |

**GASTROINTESTINAL**

| | | |
|---|---|---|
| Loss of appetite | ☐ Yes | ☐ No |
| Change in bowel movements | ☐ Yes | ☐ No |
| Nausea or vomiting | ☐ Yes | ☐ No |
| Heartburn or chronic indigestion | ☐ Yes | ☐ No |
| Frequent diarrhea | ☐ Yes | ☐ No |
| Painful bowel movements or constipation | ☐ Yes | ☐ No |
| Red blood cells in stool or tarry, black stools | ☐ Yes | ☐ No |
| Stomach pain | ☐ Yes | ☐ No |
| Hemorrhoids or rectal itching | ☐ Yes | ☐ No |

**BONES, JOINTS, MUSCLES**

| | | |
|---|---|---|
| Joint pain, stiffness, or swelling | ☐ Yes | ☐ No |
| Weakness of muscles or joints | ☐ Yes | ☐ No |
| Muscle pain or cramps | ☐ Yes | ☐ No |
| Back pain | ☐ Yes | ☐ No |
| Cold extremities (legs) | ☐ Yes | ☐ No |
| Difficulty in walking | ☐ Yes | ☐ No |

**SKIN**

| | | |
|---|---|---|
| Rash or itching | ☐ Yes | ☐ No |
| Change in skin color | ☐ Yes | ☐ No |
| Change in hair or nails | ☐ Yes | ☐ No |
| Varicose veins | ☐ Yes | ☐ No |
| Breast pain | ☐ Yes | ☐ No |
| Breast lump | ☐ Yes | ☐ No |
| Breast discharge | ☐ Yes | ☐ No |

**BRAIN & NERVOUS SYSTEM**

| | | |
|---|---|---|
| Frequent or recurring headaches | ☐ Yes | ☐ No |
| Light headed or dizzy | ☐ Yes | ☐ No |
| Convulsions or seizures | ☐ Yes | ☐ No |
| Numbness or tingling sensations | ☐ Yes | ☐ No |
| Tremors | ☐ Yes | ☐ No |
| Paralysis | ☐ Yes | ☐ No |
| Stroke | ☐ Yes | ☐ No |
| Temporary blindness | ☐ Yes | ☐ No |
| Loss of consciousness | ☐ Yes | ☐ No |
| Weakness of any extremity (leg or arm) | ☐ Yes | ☐ No |

**MENTAL HEALTH**

| | | |
|---|---|---|
| Memory loss or confusion | ☐ Yes | ☐ No |
| Nervousness | ☐ Yes | ☐ No |
| Depression | ☐ Yes | ☐ No |
| Sleep problems | ☐ Yes | ☐ No |

**ENDOCRINE**

| | | |
|---|---|---|
| Glandular or hormone problem | ☐ Yes | ☐ No |
| Thyroid disease | ☐ Yes | ☐ No |
| Excessive thirst or urination | ☐ Yes | ☐ No |
| Heat or cold intolerance | ☐ Yes | ☐ No |
| Dry skin | ☐ Yes | ☐ No |
| Change in hat or glove size | ☐ Yes | ☐ No |

**BLOOD & LYMPH**

| | | |
|---|---|---|
| Slow to heal after cuts | ☐ Yes | ☐ No |
| Easily bruise or bleed | ☐ Yes | ☐ No |
| Anemia | ☐ Yes | ☐ No |
| Past transfusion | ☐ Yes | ☐ No |
| Enlarge glands | ☐ Yes | ☐ No |

**WOMEN ONLY:**

| | | |
|---|---|---|
| Pain with periods | ☐ Yes | ☐ No |
| Irregular periods | ☐ Yes | ☐ No |
| Vaginal discharge | ☐ Yes | ☐ No |

# pregnancies: # miscarriages:

**Date of last PAP smear?** _____

Finding of last PAP: ☐ Normal ☐ Abnormal

Date of last period? _____

**Date of last Mammogram?** _____

Do you practice birth control? ☐ Yes ☐ No

If so, what type:

**Patient's Signature:** _____ **Date:** _____

☐ *I have reviewed and confirmed this information with the patient.* **Provider Signature:**

Today's Date _____ _____

# MEDICAL RECORDS RELEASE AUTHORIZATION

## PATIENT INFORMATION :

Name: (Last, First, MI) _____

Address: _____

Phone: _____ Date of Birth: _____ SS#: _____

## AUTHORIZATION :

I hereby authorize (Physician, Clinic, Hospital or other Health Care Provider) to release medical records:

From (Name of Party Releasing Records):

Name: _____

Address: _____

Phone #: _____

Date of Services: _____ to _____

To (Name of Requesting Party):

Name: HOBDARI FAMILY HEALTH

Address: 1855 Veterans Park Drive, Suite 201 - Naples, Florida, 34109

Fax #: (239) 260-1491 Phone #: (239) 260-1033 Email: info@hobdarihealth.com

## PURPOSE OF RELEASE OF MEDICAL RECORDS :

- ☐ Change in family doctor
- ☐ Specialty appointment
- ☐ Insurance claim processing
- ☐ Other (specify): _____
- ☐ Legal claim processing

The Undersigned Hereby Releases HOBDARI FAMILY HEALTH from Any and All Legal Responsibility or Liability that could occur from this Action.

Patient Signature: _____ Date: _____

# PAYMENT POLICY

Thank you for choosing HOBDARI FAMILY HEALTH as your primary care provider. We are committed to providing you with the best possible health care. In order to better serve you, we have adopted the following payment policy:

1. INSURANCE. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. CO-PAYMENTS & DEDUCTIBLES. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

3. MEDICARE & SECONDARY INSURANCE. Whether or not your secondary payer is a crossover, you are expected to pay the 20% co-payment at the time of service. Upon receiving payment from your secondary insurance company, we will refund you the payment.

4. NON-COVERED SERVICES. Please be aware that some, & perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. CLAIMS SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. COVERAGE CHANGES. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you and payment will be expected immediately.

8. NON-PAYMENT. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. A monthly interest rate will accrue to your patient balance for non-paid services. Partial payments will not be accepted unless otherwise agreed upon. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

9. MISSED APPOINTMENTS. If you fail to show up or cancel your appointment with less than a 24 hour advance notice, you will be charged a fee of $25, ($50 for a physical). As a courtesy, a reminder call is made by our staff a day prior to your appointment, but in no way does this relieve the patient of the responsibility to fulfill their scheduled appointment.

10. PAYMENTS ACCEPTED. Cash, Check, American Express, Discover, Master Card, Visa. If your check is returned for insufficient funds, we reserve the right to add a penalty charge of $35.00 to your account.

11. CHARGEABLE SERVICES. You will be charged for additional services you request including: medical form completion, phone and email consultations, and prescription refills (requested outside a scheduled visit).

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of Patient (or Responsible Party) Date

# PRIVACY PRACTICES ACKNOWLEDGEMENT & CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- ☐ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
- ☐ Obtain payment from third-party payers (your insurance company).
- ☐ Conduct normal healthcare operations, such as quality assessments and physician certifications.

I have received and reviewed a copy of the Notice of Privacy Practices (in office or printed out from website) containing a more complete description of the uses and disclosure of my health information. I understand that HOBDARI FAMILY HEALTH has the right to change its privacy notice and that I may contact HOBDARI FAMILY HEALTH any time to obtain a current copy of the Notice of Privacy Practices. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the RFH Privacy Officer, 1855 Veterans Park Drive, Suite 201 Naples, Florida, 34109

I hereby give my consent for HOBDARI FAMILY HEALTH to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). With this consent, HOBDARI FAMILY HEALTH may call, mail, or email my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

I prefer to be contacted regarding my appointment, billing, or medical care in the following manner:

☐ Home Phone: _____ ☐ Check here if you ONLY want us to leave a call back phone #

☐ Work Phone: _____ ☐ Check here if you ONLY want us to leave a call back phone #

☐ Cell Phone: _____ ☐ Check here if you ONLY want us to leave a call back phone #

☐ Written Communication ONLY (We will send all information to your home address, unless requested differently)

☐ Other (Please specify): _____

I authorize the following persons to be contacted regarding my appointments, billing, or medical care.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

By signing this form, I am consenting to allow HOBDARI FAMILY HEALTH to use and disclose my PHI to carry out TPO.

_____ _____

Signature of Patient (or Legal Guardian) Date

_____ _____

Print Patient's Name Print Legal Guardian's Name (if applicable)

Hobdari Family Health
*Lindita R. Hobdari M.D.*
1855 Veterans Park Drive, Suite 201
Naples, FL 34109
Phone: (239) 260-1033 Fax: (239) 260-1491

***Attention Patients:***

If you are scheduled for a ***preventative medicine visit*** (i.e. Well-Visit, preventative medicine, or a yearly physical exam) this visit will be submitted as a preventative exam to your insurance. Depending on your health plan's policy your insurance ***MAY or MAY NOT*** cover this visit. You may have a maximum annual cap for well benefits that is less than our charges.

If during the course of your preventative exam the physician addresses and documents a ***problem-related issue*** (i.e. hypertension, depression, diabetes, pain, acne, etc.) ***you may also receive an office visit charge***, for instance, your insurance may require you to pay two co-pays and/or deductible/coinsurance amounts for that visit. For insurance purposes, if both the physical and problem-related issues are addressed in the same visit, the preventative visit is considered a separate charge from the office visit (problem-related issues) this is because these are separate identifiable services which would typically be taken care of in a follow up visit. If your provider addresses these problems regardless if they were performed on the same day, your insurance will be charged for an office visit in addition to the preventative charge.

The physician cannot alter the coding submitted to your insurance in order for your insurance to make payment. The physician assigns codes according to the services provided regardless if they were performed on the same day; the patient assumes responsibility of any additional charges.

If you have any questions, please contact the billing department.

**Signature and Acknowledgement:**

***In signing this document, I have read, understand, and agree to the above information.***

Patient/ Patient Representative Name (Printed):_____
Signature:_____ Date:_____

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***Appointment No-Show Policy:***

It is the policy of Hobdari Family Medicine to monitor and manage appointment no-shows. This is necessary to ensure that we are able to provide timely access for all patients to our providers. Undue numbers of unutilized appointments delays necessary medical care for patients. Scheduled appointments must be cancelled or rescheduled at least 24 hours prior to the scheduled appointment time. Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled is considered a "no-show".

***Office appointments which are not cancelled or rescheduled with 24 hours notification may be subject to a $50.00 cancellation fee.***

Front office supervisor may exercise limited discretion in assigning "no-shows" so as to account for special circumstances. These special circumstances shall be narrow in scope and would meet the general test of an unavoidable circumstance experienced by the patient such as hospitalization, or other emergency.

**Signature and Acknowledgement:**

***In signing this document, I have read, understand, and agree to the above information.***

Patient/ Patient Representative Name (Printed):_____
Signature:_____ Date:_____

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## ***Patient Consent Agreement For Chronic Care Services:***

Medicare now offers a new benefit for patients with multiple chronic diseases, and by consenting to this agreement you designate your provider, Lindita Hobdari, MD., to provide chronic care management (CCM) services per Medicare guidelines. Only patients with more than one chronic condition are eligible for this benefit and your provider agrees not to bill Medicare for this service if you do not have more than one chronic condition. Medicare defines a chronic condition as one that is expected to last at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.

**Provider Chronic Care Services:**

As part of this new benefit, your provider agrees to make available the following services:

1. 24/7 access to a healthcare provider to address your acute chronic care needs
2. Use of certified HER software to document your care
3. Provide a written or electronic version of your care plan
4. Perform medication reviews and oversights
5. Assist in the management of transitions of care from one provider to another

In connection with this new benefit your provider agrees to bill Medicare just one time per each 30-day billing cycle and if you revoke this agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.

**Beneficiary Consent Terms:**

By signing this agreement, you agree to the following terms required by Medicare:
You consent to your provider providing CCM services to you

1. You acknowledge that only one practitioner can furnish CCM services to you during a 30-day period
2. You authorize electronic communication of your medical information with other treating providers to facilitate the coordination of care
3. You understand that the Medicare co-insurance amount applies to CCM services
4. You have the right to stop CCM services at any time by revoking this agreement at the end of the current 30-day period by notifying our practice in writing

**Signature and Acknowledgement:**

***In signing this document, I have read, understand, and agree to the above information.***

Patient/ Patient Representative Name (Printed):_____
Signature:_____ Date:_____

# Dr. Hobdari's Beautification Procedures Price List

## Individual Procedures

**Botox - $18.00** *per unit*

**Radiesse - $950.00** *per syringe*

**Juvederm/Restylane - $750.00** *per syringe*

**Belotera - $750.00** *per syringe*

**Voluma (Cheek Augmentation) - $1200.00** *per syringe*

**Kybella - $600.00** *per vial*

**Sculptra - $1250** per vial

**Myer's Cocktail - $300.00** *per IV treatment*

**Glutathione Package - $100.00** *(includes 4 injections)*

- **$40.00** *per injection*

## Laser Treatments

***(ALL LASER APPOINTMENTS REQUIRE CONSULTATION)***

**Laser Consultation - $100.00** ***(*required*)***

**IPL (Sun Damage) - $1500.00**

**Rejuvenation/Wrinkle Treatment – 3,500.00**

**Stretch Mark/Scar Treatment – 3,500.00**

**Skin Tightening - $3,500.00**

**Spider Vein Treatment - $500.00** *per leg*

**Hair Removal (*dependent on treatment area)***

- ✓ **Upper Lip Hair Removal - $500.00**
- ✓ **Laser Deposit - $100.00**
- ✓ **Chin/ Eyebrow/Face/Neck $500.00**
- ✓ **Aeriola Area - $500.00**
- ✓ **Under Arm - $1,000.00**
- ✓ **Upper Arm/Forearm - $1.250.00**
- ✓ **Bikini Full - $1,250.00**
- ✓ **Brazilian Bikini - $1,250.00**
- ✓ **Upper/Lower Leg - $1,500.00**
- ✓ **Full Leg/ Back - $2,000.00**