



visit our website www.GetMeGreatSkin.com

PLEASE FILL OUT BOTH SIDES OF THESE TWO FORMS (8 sides) AND RETURN TO FRONT DESK

Date _____ NAME: _____
(Last, First, Middle)

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: () _____ CELL () _____

E-MAIL: _____

Your e-mail will Not be given out. Will be used only for emergency contact, for skin health updates or office info.

SEX: M F OCCUPATION: _____

Check if Minor (less than 18) Marital Status: Single Married Divorced Widowed Separated

EMPLOYER: _____

EMPLOYER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

WORK PHONE #: () _____

DATE OF BIRTH: ____/____/____ AGE: _____ S.S. #: _____

SPOUSE'S / PARENT'S / GUARDIAN'S NAME: _____

EMPLOYER: _____ PHONE #: () _____

• MEDICAL EMERGENCY CONTACTS: (LIST NAMES & PHONE #S)

NAME: _____ PHONE #: () _____

NAME: _____ PHONE #: () _____

Pharmacy Name: _____ CITY: _____ STREET: _____

• REFERRED BY: (circle one) DOCTOR / YELLOW PAGES (Big or Little) / SIGN / INS. BOOK / RADIO / FRIEND / FAMILY / NEWSPAPER / INTERNET- WEBSITE NAME: _____ OTHER: _____

NAME OF FRIEND OR DOCTOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE #: () _____

NAME OF PRIMARY CARE DOCTOR _____
IF NOT LISTED ABOVE:

• HEALTH INSURANCE INFORMATION:

PRIMARY INSURANCE NAME:

NAME OF INSURED: _____

RELATIONSHIP TO PATIENT: PARENT SPOUSE SELF OTHER M F

DATE OF BIRTH: ____/____/____ INSURANCE ID #: _____

S.S. # OF INSURED: _____

EMPLOYER/GROUP NAME: _____ GROUP #: _____

CO-PAY AMOUNT \$ _____

DO YOU HAVE A DRUG OR PRESCRIPTION PLAN? YES / NO

* If ever a change in insurance information or medical condition it is important you inform us.

SECONDARY INSURANCE NAME:

NAME OF INSURED: _____

RELATIONSHIP TO PATIENT: PARENT SPOUSE SELF OTHER M F

DATE OF BIRTH: ____/____/____ INSURANCE ID #: _____

S.S. # OF INSURED: _____

EMPLOYER/GROUP NAME: _____ GROUP #: _____

• PLEASE READ THIS STATEMENT BELOW CAREFULLY AND SIGN:

All information on all eight sections of this form including the **Medical History & Financial Policy** Form are true and complete. **I agree to inform you on subsequent visits if any Medical History or Insurance Information changes, or if I move.** My signature will also be used as "signature on file" for insurance purposes including any medical information necessary to process the claim. I give permission for medical photographs to be taken and they may be used for educational purposes.

I hereby assign my insurance benefits to be paid directly to Advanced Dermatology, P.C.

I have read Advanced Dermatology's financial policy and agree that I am ultimately responsible for all non-covered services, and broken appointments, rendered to me or my dependents.

Print Patient's Name

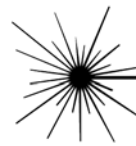
Patient's Signature or Guardian

I have read the HIPAA consent, on page 3 and if I do not sign this form below, Advanced Dermatology, PC may decline to provide treatment to me. My signature below states that I agree with it's contents.

Print Patient's Name

Patient's Signature or Guardian

HIPAA CONSENT
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION



With my consent Advanced Dermatology PC may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Advanced Dermatology PC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices. Advanced Dermatology PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Dermatology PC Privacy Officer.

With my consent Advanced Dermatology PC may call my home or other designated 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, prescription renewals, lab results, Insurance items and all other Protected Health Information* ("PHI") and return calls requesting a call back.

Other Designated Numbers:

() - Home / Office / Cell / Other: _____

() - Home / Office / Cell / Other: _____

() - Home / Office / Cell / Other: _____

With my consent, on the front page Advanced Dermatology PC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

◆ I agree that my PHI may be shared with my spouse & the following other people.

With my consent, Advanced Dermatology PC may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Advanced Dermatology PC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent.

***THE COMPLETE HIPAA GUIDELINES ARE AVAILABLE AT THE FRONT DESK FOR YOUR REVIEW.**

FINANCIAL POLICY

Thank you for selecting Advanced Dermatology, P.C. for your dermatological cares. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical and/or any laboratory fees, the following is provided.

HMO/PPO/Other Insurance Coverage: If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a driver's license.

All co-payments are due prior to seeing the physician. If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. You will be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

If you have coverage with an insurance carrier with which we do not participate ("out of network"), payment is due at the time of service. We will provide you with a receipt that you can submit to your carrier for reimbursement, if applicable.

Medicare: Our physicians are participating Medicare providers and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy we will submit to that particular carrier any remaining balance. You will also be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

Laboratory: Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

Self-Pay Patients (Will Pay): Patients with no insurance, the guarantor is responsible for the bill at the time of service.

Cosmetic Patients: Deposits are required prior to the date of the procedure. The balance of the payment is required prior to the procedure being performed.

Payments: We utilize a guaranteed check service, which automatically deducts the amount of your check from your account immediately. This is similar to how your credit or debit card works by showing us if funds are available in your account.

Refund Policy: We do not offer refunds on medical and cosmetic procedures.

Cancellation Policy: A charge will be made for broken appointments unless 24 hours notice is given.

Returned Checks & Collections: A charge of \$25 will be made for all returned checks. In the event that any action is brought to collection, you agree to pay any reasonable collection costs and/or attorney fees.

MEDICAL HISTORY

PLEASE FILL OUT BOTH SIDES OF THIS FORM AND RETURN TO FRONT DESK

PRINT NAME: _____

REASON FOR TODAY'S VISIT/CHIEF COMPLAINT: _____

When was your last physical examination? _____

Physician's Name: _____

Phone #: _____

We strongly recommend a complete body skin exam for skin cancer screening on initial visit. Do you want one? Yes No

Have you ever been seen in any Advanced Dermatology office (including this office)? Yes No

When? _____ Which office? _____

Seen by any other Dermatologist? Yes No

Whom/When/For what problems? _____

HAVE YOU EVER HAD OR HAVE:

1. ALLERGIES: (Medications) Allergic reaction to any medicines: Penicillin Yes No Lidocaine Yes No

Other: _____ What happened: _____

2. PAST MEDICAL HISTORY: Arthritis Yes No Asthma/Bronchitis Yes No Bleeding Problems Yes No Cancer Yes No Type/When _____ Chemotherapy Yes No Chicken Pox Yes No Circulatory Problems Yes No Diabetes Yes No Insulin Dependent Yes No Drug or Alcohol Abuse Yes No

Past Operation(s)/Other Diseases: (what/when/explain) _____

Xray/Radiation Therapy Yes No When/Where: _____

3. FAMILY HISTORY:

Basal Cell Carcinoma Yes No Squamous Cell Carcinoma Yes No Melanoma Yes No Who/Location: _____ Allergies Yes No Type: _____ Hay Fever Yes No Asthma/Bronchitis Yes No Psoriasis Yes No Eczema Yes No Lupus Yes No Other Skin Conditions/Explain: _____

5. MEDICATION (S): Yes No

CURRENT ORAL MEDICATIONS, HERBS, HEALTH FOODS, BIRTH CONTROL PILLS, ETC.

Aspirin/Aleve/Advil/etc. Yes No Blood Thinners Yes No Accutane Yes No Past use of Accutane? Yes No If Yes When? _____

CURRENT TOPICAL & OVER-THE-COUNTER MEDICATIONS & CREAMS: _____

6. PERSONAL SKIN HISTORY:

Basal Cell Carcinoma Yes No Squamous Cell Carcinoma Yes No Melanoma Yes No Location/Year/Depth _____ Allergies: Food Yes No If Yes What Type: _____ Environment Yes No If Yes What Type: _____ Hay Fever Yes No Psoriasis Yes No

4. SOCIAL HISTORY:

Do you smoke? Yes No Do you drink alcohol? Yes No Do you use drugs? Yes No Do you have regular Periods? Yes No Are you using birth control pills / patch / injection? Yes No Are you pregnant now? Yes No Have you ever been pregnant? Yes No Number of Pregnancies: _____

Eczema Yes No Have you ever had a sunburn?# of times _____ Yes No Other Skin Conditions: _____

Explain: _____

Have you ever had any cosmetic or plastic surgery procedures performed on you? Yes No Explain Procedures & When: _____

LIST OTHER OPERATIONS, SURGERY OR DISEASES: _____

GENERAL INFORMATION: Height _____ Blood Pressure ___/___ Weight _____ lbs.

OTHER PERTINENT INFORMATION: _____

WE OFFER A WIDE VARIETY OF SERVICES - (Partial Listing)

Are you interested in any of these services?

- Yes No Age Spots/Sun Spots
- Yes No Beautiful Eyes
- Yes No **Botox® / Dysport®**: Facial Wrinkles
- Yes No Broken Blood Vessels/Spider Veins
- Yes No Chemical Peel for Pigmentation/Melasma
- Yes No Earlobe Repair
- Yes No Excessive Fat/Cellulite/Liposuction
- Yes No **Fillers:** Restylane®, Perlane®, Fat, Radiesse®, Juvederm®: Ultra & Ultra Plus, Sculptra®
- Yes No Growth Removal
- Yes No Hair Transplants - NaturalSM Technique
- Yes No Laser Treatments for Acne
- Yes No Laser for Psoriasis or Loss of Pigmentation
- Yes No Microdermabrasion
- Yes No Patch Testing for Skin Allergies
- Yes No Permanent Hair Removal (Reduction)
- Yes No Scars-Acne, Traumatic, etc.
- Yes No Skin Rejuvenation
- Yes No Stretch Marks
- Yes No Tattoo Removal
- Yes No **Thermage®** - Non-Surgical Skin Tightening
- Yes No Varicose Veins
- Yes No Wrinkle/Jowls/Rejuvenation **with downtime**
- Yes No Wrinkle/Jowls/Rejuvenation **without downtime (Ulthera®/Fraxel®/Harmony®/Smoothbeam®)**

NEW-No Downtime, Non-Surgical Facelift
ULTHERA®LIFT - Excellent for Jowls, Neck, Jawline, etc.

We Offer Cosmetic and reconstructive procedures for men & women

FACE AND HEAD

- Yes No Ear Surgery
- Yes No Eyelid Lift-Upper & Lower
- Yes No Facelift
- Yes No Neck Lift
- Yes No Nose Surgery

BODY

- Yes No Arm Lift
- Yes No Buttock Contouring
- Yes No Tummy Tuck

BREASTS

- Yes No Breast Augmentation
- Yes No Breast Lift
- Yes No Breast Reduction

SKIN

- Yes No Scar Revision
- Yes No Facial Suturing

ARE YOU INTERESTED IN OUR SKIN CARE LINE FOR:

- Acne
- Moisturizers: Eye,Face, Body
- Skin Discolorations
- Hair Products
- Reducing Fine Lines/ Wrinkles
- Skin Rejuvenation/ Healthier Skin
- Sun Screens

Any Other Product(s) Interested In _____

Visit Our Website @ www.GetMeGreatSkin.com

For a Complete Line of Products to Help "Get Me Great Skin"