

PLEASE PRINT VERY CLEARLY

Line items printed in **bold** on this page are required fields, if they apply. Thank you for your assistance.

■ **Patient Information**

Name (Last, First, Middle) _____ Today's Date _____
Birthdate _____ Soc. Sec. # _____ Home Phone _____
Email address _____ Cell Phone _____
Address _____ Work Phone _____
City _____ State _____ Zip _____ Sex: M F
 Check if Minor (less than 18) Marital Status: Single Married Divorced Widowed Separated
Referring Physician _____ Phone _____

■ **Primary Insurance**

Insurance Company _____
Insurance ID # _____ Group # _____
Please enter the policyholder's information below. If you are the policyholder yourself, check this box and skip to the next section.
Policyholder's Name (Last, First, Middle) _____
Relationship to Patient _____ Soc. Sec. # _____ Birthdate _____
Address _____ Home Phone _____
Employer _____ Work Phone _____

■ **Secondary Insurance** *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company _____
Insurance ID # _____ Group # _____
Please enter the policyholder's information below. If you are the policyholder yourself, check this box and skip to the next section.
Policyholder's Name (Last, First, Middle) _____
Relationship to Patient _____ Soc. Sec. # _____ Birthdate _____
Address _____ Home Phone _____
Employer _____ Work Phone _____

■ **Assignment and Release**

I hereby authorize payment directly to Kahn Dermatology, PLLC of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

Patient Name: _____

Date: _____

Medical Information

Please state the reason(s) for your visit today: _____

Primary Care Physician's Name _____ Phone _____

Preferred Pharmacy Name _____ City & State _____

Pharmacy Telephone Number _____ Pharmacy Fax _____

1. Are you currently under medical treatment? Yes No
Please describe: _____

2. Have you ever had any serious illnesses or operations? Yes No
Please describe: _____

3. Are you taking any medications? Yes No
Please list: _____

4. Do you smoke? Yes No

5. Do you drink alcohol? Yes No

6. Do you use cocaine or other drugs? Yes No

7. Have you had any allergic reactions to the following:
Local Anesthetics (eg. Novocaine)..... Yes No
Penicillin or other Antibiotics Yes No
Sulfa Drugs Yes No
Barbiturates (sleeping pills)..... Yes No
Other Sedatives Yes No
Iodine Yes No
Aspirin Yes No
Other Yes No
Please describe: _____

8. Women Only:
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: _____

Please indicate which of the following conditions/illnesses you have or have not had:

Yes No
Anemia (low blood count)..... Yes No
Anorexia (no appetite) Yes No
Arthritis Yes No
Asthma Yes No
Back Problems Yes No
Bleeding Tendency..... Yes No
Blood Disease Yes No
Cancer..... Yes No
Chemical Dependency (drug addiction) .. Yes No
Chemotherapy..... Yes No
Chicken Pox Yes No
Chronic Fatigue Syndrome Yes No
Circulatory Problems Yes No
Congenital Heart Lesions..... Yes No
Cough – persistent or bloody Yes No
Diabetes Yes No
Emphysema..... Yes No
Epilepsy..... Yes No
Glaucoma Yes No

Yes No
Heart Murmur Yes No
Heart Disease Yes No
Hepatitis – Type ____ Yes No
Hernia Yes No
Herpes Yes No
High Blood Pressure Yes No
HIV / AIDS..... Yes No
Jaundice..... Yes No
Kidney Disease Yes No
Latex Sensitivity Yes No
Liver Disease Yes No
Low Blood Pressure Yes No
Measles..... Yes No
Migraine Yes No
Headaches..... Yes No
Mitral Valve Prolapse Yes No
Mumps Yes No
Multiple Sclerosis Yes No
Pacemaker..... Yes No

Yes No
Pneumonia Yes No
Polio Yes No
Prostate Problem..... Yes No
Psychiatric Care Yes No
Respiratory Disease Yes No
Rheumatic Fever Yes No
Scarlet Fever Yes No
Shortness of Breath..... Yes No
Sinus Trouble Yes No
Skin Rash..... Yes No
Stroke Yes No
Thyroid Problems..... Yes No
Tonsillitis..... Yes No
Tuberculosis Yes No
Ulcer Yes No
Venereal Disease Yes No
Any Other Condition Yes No
Please Describe: _____

BILLING AND COLLECTION POLICIES

Upon scheduling and registration we require you to provide your medical insurance card (if you have coverage), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's address, date of birth, and phone number as well. Our billing process works better if you provide social security numbers as well.

Health Insurance Cards: Please bring your most current health insurance membership card to each and every appointment. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report it. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: Should you not arrive for a scheduled appointment, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged \$20 for each no-show occurrence. (This charge does not apply to Federal & State plan beneficiaries.) Should you no-show twice or more within a 12 month period, you may be dismissed from the practice.

Health Insurance Plans: As helpful as we pride ourselves on being, our team cannot be expected to know the details of your particular plan, as we see hundreds of different plans every week. You, and you alone, are responsible to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your financial responsibilities. Please bear in mind that, ultimately, carrier adjudications *after* the visits determine financial responsibilities.

Referrals: You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours. If your plan requires a referral or authorization that you do not obtain, and your health plan refuses to pay for any claim for lack of a referral or authorization, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense). If you come to an appointment that requires a referral and you do not have one, and you must reschedule, you may be charged \$30 for a no-referral cancellation (except for Federal & State plan beneficiaries).

Copayments: If your plan has a copayment, it is your responsibility to pay it at the time of service. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, you will be responsible to pay a delayed payment fee of \$10 (except for Federal & State plan beneficiaries).

Financial Security: It is our policy to require patients to keep a credit card on file as financial security against deductibles, co-insurance and other instances of patient balances due to us as outlined in this document. As of implementation of this policy, patient balances as determined by these policies and/or insurance carrier explanation of benefit forms shall be charged to the credit card on file (see Payment Security Authorization form). Patients shall be invoiced via mail once if the balance exceeds the maximum charge per incidence or if the card is denied. Should payment in full not be received [Note: this means actually received by us, not postmark date] within ten (10) business days, your account may be assessed a \$25 fee (except Federal & State plan beneficiaries) and sent to our collection agency. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

Health insurance non-payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your financial responsibility to pay in full. This includes cases of retroactive disenrollment.

Self-pay patients: If you do not have health insurance, have coverage with which we do not participate, or are receiving a known non-covered service, it is our policy that you must pay for your service in full before leaving the office. Some cosmetic services require a deposit upon scheduling, which may be taken over the telephone and charged to a credit card, and are not refundable. Should your credit card subsequently be declined or charged back, you will still be responsible for the deposit amounts.

Hardship discount: Uninsured patients whose proven family earnings fall below 200% of the federal poverty level are eligible for a hardship discount for non-cosmetic services, which reduces out-of-pocket costs to match Medicare reimbursements, but only if requested in advance.

I have read, fully understand, accept and explicitly agree with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Kahn Dermatology, PLLC for any services furnished to me or my dependents.

Patient Name (Please print clearly): _____

Signature of Patient: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

◆ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

◆ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information* ("PHI"), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

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

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

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

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

◆ I agree that my PHI may be shared with my spouse.

◆ I agree that my PHI may be shared with my other medical providers.

◆ I agree that my PHI may be shared with the following other people:

_____	_____
_____	_____
_____	_____
_____	_____

◆ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Sondermatology, PC to the attention of the HIPAA Compliance Officer.

◆ I agree that my PHI may be shared with my credit card company/companies if I contest any credit card charges, so that Kahn Dermatology, PLLC can submit records to support its charges.

◆ I agree that Kahn Dermatology, PLLC may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (Please print clearly): _____

Signature: _____ Date: _____

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ Relationship to Patient: _____

AESTHETIC INTEREST QUESTIONNAIRE

Please complete this questionnaire and hand it directly to your provider in the exam room. Thank you.

Name: _____

Date: _____

Areas of concern or interest to you (please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Frown lines between the brows | <input type="checkbox"/> Red spots / Rosacea |
| <input type="checkbox"/> Lines around nose and mouth | <input type="checkbox"/> Facial vein removal |
| <input type="checkbox"/> Tired-looking skin / Uneven skin tone | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Clogged or large pores | <input type="checkbox"/> Brown spots / Age spots / Sun damage |
| <input type="checkbox"/> Brown patches / Melasma | <input type="checkbox"/> Eyelash length |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hair removal |
| <input type="checkbox"/> Scars (acne or surgical) | <input type="checkbox"/> Laser facial treatment |
| <input type="checkbox"/> Leg vein removal | <input type="checkbox"/> Deep wrinkles or lines; Facial laxity |
| <input type="checkbox"/> Dark circles under the eyes | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Fuller lips | _____ |

Which aesthetic procedures are you interested in?

- | | |
|---|--|
| <input type="checkbox"/> Botox | <input type="checkbox"/> Laser rejuvenation |
| <input type="checkbox"/> Chemical peels | <input type="checkbox"/> Laser skin tightening |
| <input type="checkbox"/> Fractionated laser resurfacing | <input type="checkbox"/> Laser facial / Intense Pulsed Light (IPL) |
| <input type="checkbox"/> Laser treatment of facial or leg veins | <input type="checkbox"/> Laser hair removal |
| <input type="checkbox"/> Laser treatment of facial redness | <input type="checkbox"/> Other, please specify: _____ |
| <input type="checkbox"/> Dermal filler (ie. Juvederm, Radiesse) | _____ |

Would you be interested in a skin care regimen for home use?

- YES
 No, thanks