



# Cosmetic Interest Form

Dear Patient and Friend:

If you are interested in any of our cosmetic products or services, please take a moment to fill out your contact information below.

Please check one:  New patient  Established Patient  Other

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Preferred Method of Contact:  Home Phone  Cell Phone  Email

Are you 18 years of age or older?  Yes  No

**Check here if you would like to receive our monthly newsletters and special offers via email.**

**Please check any cosmetic services you are interested in learning more about:**

- Laser Hair Removal
- PhotoFacial Skin Rejuvenation for brown spots and redness
- V-Beam Laser Treatment for Rosacea
- Fraxel® Laser Skin Resurfacing
- Chemical Peels
- Microdermabrasion
- Acne Scar Reduction
- Coolscluping/Zeltiq™ Permanent Fat Reduction
- Botox® Cosmetic Injections
- Dermal Fillers such as:
  - Restylane and Perlane
  - Juvéderm and Juvéderm Ultra +
  - Radiesse
  - Sculptra
  - Sclerotherapy for spider veins
- Skin Care Products

**For Office Use Only**

**Completed by:** \_\_\_\_\_

- Consultation Same Day
- Consultation Scheduled for \_\_\_\_\_
- Telephone Consultation/Information Mailed
- Procedure Scheduled Date: \_\_\_\_\_ Type: \_\_\_\_\_
- Sent to PR Boutique/Constant Contact

Comments: \_\_\_\_\_

# MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

General Health:     Poor         Fair         Good         Excellent

Are you allergic to any medication?  No         Yes If yes, list:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

Reaction to allergy:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

List all medications you are currently taking and dosage:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Other physician(s) involved in your care: (name, address, telephone number)

## MEDICAL HISTORY:

Do you have now, or have you ever had diseases or conditions of: (Please √ if self or family member)

	Self	Family		Self	Family		Self	Family
Bronchitis			Diabetes			Skin Cancer		
Emphysema			Thyroid			Cancer		
Asthma			Kidney			HB Pressure		
Bladder			Chronic Cough			Chest Pain		
Stomach			Morning Cough			Heart Attack		
Bowel			Heart Murmur			Hepatitis		
Glaucoma			Irregular Heart Beat			Arthritis		
Convulsions			Phlebitis (Blood Clot)			Pacemaker		
Other _____			HIV/ Aids			Fainting		

List any surgeries you have had in the last 12 months: \_\_\_\_\_

Do you drink alcohol?         No     Yes    If yes, \_\_\_\_\_ drinks per day

Do you smoke?                 No     Yes    If yes, how much/long? \_\_\_\_\_ / \_\_\_\_\_

Do you bleed easily?         No     Yes    Have you been exposed to HIV?     No     Yes

Do you have artificial Joint(s)  No     Yes    (Women) Are you pregnant?     No     Yes

Have you ever had dental anesthesia (Xylocaine)?     No     Yes    Any bad reaction?  No     Yes

**Skin:**

When you are exposed to sun do you:     Tan only                     Tan and Burn                     Burn

Do you have a history of any specific skin diseases?     No     Yes

If yes, please list: \_\_\_\_\_

Reason for your visit today:

Duration: \_\_\_\_\_ Location: \_\_\_\_\_ Symptoms: \_\_\_\_\_

Has this condition changed over time?     No     Yes

If yes, how? \_\_\_\_\_

Any past treatment?             No     Yes    If yes, by whom? \_\_\_\_\_

Any response to treatment?     No     Yes    If yes, what? \_\_\_\_\_

Physician Initials \_\_\_\_\_

PATIENT INFORMATION			
First	Middle	Last	
Address	City	State	Zip
Home Phone	Cell Phone	Emergency Contact	Emergency Phone
Date of Birth	Sex	Marital Status	Social Security No.
Referring Physician	Employer		Work Phone
BILLING INFORMATION			
Person Responsible for Bill:	Address (if different from above)		Home Phone
INSURANCE INFORMATION		<input type="checkbox"/> SEE ATTACHED INSURANCE CARD(S)	
<b>Primary Insurance</b>			
Insurance Address	Insurance Address		Insurance Phone
Group Number	Policy Number		Insured's relationship to pt: circle one self spouse child other
Subscriber's Name	Address		Phone
Subscriber's Date of Birth	Sex	Social Security No.	Employer
<b>Secondary Insurance</b>			
Insurance Address	Insurance Address		Insurance Phone
Group Number	Policy Number		Insured's relationship to pt: circle one self spouse child other
Subscriber's Name	Address		Phone
Subscriber's Date of Birth	Sex	Social Security No.	Employer
<b>Third Insurance</b>			
Insurance Address	Insurance Address		Insurance Phone
Group Number	Policy Number		Insured's relationship to pt: circle one self spouse child other
Subscriber's Name	Address		Phone
Subscriber's Date of Birth	Sex	Social Security No.	Employer

**AUTHORIZATION:** I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed. \_\_\_\_\_ Initials

**ASSIGNMENT OF BENEFITS STATEMENT:** I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or changes are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred. \_\_\_\_\_ Initials

**ACKNOWLEDGMENT OR RECEIPT OF PRIVACY NOTICE:** I hereby acknowledge receipt of the Notice of Privacy Practices (attached) given to me by Advanced Dermatology. \_\_\_\_\_ Initials

**ACKNOWLEDGMENT OF OFFICE POLICIES (NO-SHOW AND CANCELLATIONS):** I hereby acknowledge receipt of the Office Policies including No-Show and Cancellation Policies given to me by Advanced Dermatology. \_\_\_\_\_ Initials

**PHONE NUMBER TO CALL WITH ANY REPORTS OR LAB RESULTS:** \_\_\_\_\_

- You have my permission to leave a message at the above number
- You have my permission to discuss my medical care with \_\_\_\_\_
- Do not** discuss my medical care with anyone but me

Signature of Patient / Parent / Guardian / Insured

Printed Name

Date

## **ADVANCED DERMATOLOGY AND SKIN CARE, P.A.**

### **CONSENT FOR TREATMENT**

I hereby consent to all medical and surgical procedures, including but not limited to laboratory, biologic tests and administration of local anesthesia which are deemed appropriate and necessary at any time while under the care of the physicians at Advanced Dermatology and Skin Care, P.A.

Tissue samples may be needed to diagnose your condition. Both malignant and benign growths and conditions may require a surgical procedure called a biopsy. A local anesthetic is used prior to taking this tissue sample. This simple procedure carries with it minor risks such as: allergic reactions to the anesthesia, fainting, mild discomfort, minimal bleeding, the possibility of minor scarring and infection. The risks of not having the procedure done should be discussed with the physician.

It is the policy of this office to send all surgically removed specimens for expert consultation regardless of the pre-biopsy diagnosis. You may be responsible for any charges not covered by your health insurance.

I have read the above statements and understand the risks associated with a tissue biopsy. I also agree to have a biopsy performed by the practitioner if clinically indicated and sent to a pathology laboratory for analysis. I am aware that any outside services not covered by my insurance are my responsibility. I also authorize: Advanced Dermatology and Skin Care, P.A. physicians to release any information regarding my examination or treatment to my insurance company for processing of claims and/or to my referring physician.

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**SIGNATURE OF PATIENT (OR PARENT OR RESPONSIBLE PARTY)**

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**PRINTED NAME**

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**DATE**



## Office Policies and Information

**Business Hours:** Pearland/ Sugar Land/ Katy Office Monday to Friday, 8:00 am to 5:00 pm

**Established**

**Patients:** Established patients will be required to fill out forms every year or as requested.

**Return checks:** There is a \$50.00 charge for all returned or canceled checks.

**Late or Missed Appointments:** If you are unable to keep your appointment, please reschedule at least two days prior to your visit to allow someone else to take your place. If you arrive too late to be accommodated you may be rescheduled or worked in depending upon our schedule. **If you do not show up for your appointment, we will bill you a \$25.00 appointment fee.**

**Financial:** You acknowledge full responsibility for the payment of such services and agree to pay at the time of service. You also, understand that insurance coverage is an arrangement between the insurance carriers and the patient. We may bill your insurance company as a courtesy, but you are ultimately responsible for payment should your insurance fail to pay within 90 days.

Advanced Dermatology offers a 20% "prompt payment" discount for services which are paid in full at the time of service. This discount applies to our standard fees, not to any contractually reduced fees and is available to anyone, unless your insurance policy prohibits it. You are responsible for notifying our staff if you are choosing to be seen and not utilizing your insurance.

**Attention Texas Medicaid clients:** You understand that Advanced Dermatology and Skin Care's physicians are **NOT** a Texas Medicaid provider and therefore, the services or items that you have requested to be provided to you on all dates of service will not be covered under Texas Medicaid. **You will be accepted as a private pay patient at the time services are provided.** You also understand that you are responsible for payment for all services or items you request and receive by Advanced Dermatology and Skin Care's physician. Our charges are an estimate of each insurance company's fee schedule. You may be asked to pay this estimated amount. After your insurance processes the claim and if a balance is due you will receive a statement, or if a refund is due we will be happy to mail you a refund.

It will be your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Insurance company gives us 90 days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide correct information the visit will be your responsibility. **Accounts turned over to a collections agency will be assessed a \$25.00 fee.** You may also be given notice legally dismissing you from our practice and be asked to find another physician. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed.

There will be a **\$25.00 charge for medical records released** to legal or other professional organizations.

**Co-payments & Deductible:** Co-payments are amounts that you have agreed to pay at each doctor's office visit with your insurance company. Many insurance plans also include an annual deductible amount that is your responsibility. Please be prepared to pay both at the time of your visit. **We will not file a secondary insurance for an office visit co-payment.**

Remember that payment for **all co-pays and deductibles is due at the time of your appointment.** Co-pays for office visits are usually higher for specialists (like dermatologists) versus primary-care physicians. So check with your insurance carrier to determine if you have a higher co pay for specialists. **If one of our providers performs any of the following: biopsy, injecting, curettage (scraping), electrodesiccation (burning), freezing or excising a lesion or growth your insurance company will consider it an office surgery or procedure. Such outpatient surgeries and procedures are often subject to separate deductibles and/or co-insurance.** Again, check with your insurance carrier to determine how your benefits apply.

**Authorization for Certain Treatment:** POS and HMO insurance plans require that you obtain an authorization for treatment. We must have your authorization in hand before we can see you. Otherwise, the insurance company will not pay for your visit or prescriptions. Without a referral you have the option to receive services at a fee for service basis.

**Cosmetic Appointments:** To ensure your appointment a **\$100.00 deposit** is required for certain procedures. You will forfeit this amount if you no show for your scheduled appointment. **Cosmetic services are non-refundable and non-transferable. There are no refunds on medical grade products.**

**Cosmetic Procedures:** Your insurance company may consider some dermatological problems to be medically unnecessary to treat. **In most cases skin tags; benign moles and seborrheic keratoses are generally not covered by your carrier. If you want these growths removed, we will be happy to do it on a fee-for service basis.** Check with your doctor or our front office staff for the cost of these procedures before you have them treated. Our objective is to avoid any surprises for you at check out.

**Policy:** We reserve the right to immediately cancel your care for conduct, non-cooperation or non-payment.

**My signature below indicates that I have read and am in agreement with all statements.**

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date