

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. The federal Government requires the following notification regarding privacy.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Office Manager.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____

Signature _____ Date: _____

Dear Patient,

Dr. Rosenbach provides what he feels is the best care that is appropriate for your health or health maintenance. This letter is to inform you that although these services are important for maintaining or assuring you optimum health, they may not be covered by your insurance company.

Your insurance carrier may use the terms "medically unnecessary", "routine", "not covered", or "preventive care" to deny coverage for certain services including routine exams, laser treatments, injections, and laboratory tests. Furthermore, carriers may claim to cover "routine care" but this "coverage" may not be as comprehensive as you expect.

Since there is no consistency amongst the multitude of insurance carriers, my office cannot keep up with which carriers cover which services. Although we can help you by corresponding with your insurance carrier to appeal denied claims, we cannot predict the outcome of the claim reviews. You may want to check with your carrier prior to being seen to verify that coverage is available for expected services.

Your signature verifies that you understand that services provided may not be covered by your policy and that you are financially responsible for these services even if deemed unnecessary or unpayable by your carrier.

AUTHORIZATIONS:

Authorization to Pay Benefits to Physician:

I hereby authorize payment directly to the above named physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described on attached claim, this may not represent the full payment of services rendered and I will be responsible for the balance due. I also hereby authorize above named physician to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of evaluation for payment.

Signed: _____

Print Name: _____

Date: ____/____/____

Last Name: _____

DATE: ____/____/____

First Name: _____ Middle Name: _____

Sex: *Male or Female (Circle)* Date of Birth: ____/____/____

Age: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Country: _____

Home Phone: (____) _____ - _____

Message Phone #: (____) _____ - _____

E-Mail Address: _____

Social Security #: _____ - _____ - _____

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

Emergency Contact: _____

Emergency Contact Phone: (____) _____ - _____

Referred By: _____

Family Doctor: _____ Dermatologist: _____

Occupation: _____ Employer: _____

Employer Address: _____

Employer Phone: (____) _____ - _____ Ext: _____

MEDICAL INSURANCE PLANS:Primary Insurance Name & Address: _____

Subscriber: _____ Group #: _____

Cert#: _____

IF YOU ARE UNDER THE AGE OF 18 OR UNDER THE CARE OF A LEGAL GUARDIAN:

Responsible Party Name: _____

Responsible Party Address: _____

Responsible Party Home Phone: (____) ____ - ____

Responsible Party Social Security #: ____ - ____ - ____

MEDICAL HISTORY:Reason for Consultation: _____

Previous Serious or Chronic Illness: _____

Previous Operations: _____

List Present Medications: _____

Drug Allergies: _____

Cosmetic Procedures(e.g., chemical peels, collagen, sclerotherapy, plastic surgery, etc. – include dates)

What Brands of Cosmetic Products Do You Use(e.g. soaps, moisturizer, glycolic, eye cream, etc?)

Do You Take Aspirin Regularly? Yes or No**Have You Ever Taken Accutane?** Yes or No **Date Stopped?** ____/____/____**Have You Ever Taken Cortisone?** Yes or No **Date Stopped?** ____/____/____**Do You Have or Have You Ever Had, Any of the Following?****If So, Please Give Dates & Details:**

Easy Bruising/Bleeding Tendencies?	No or Yes	_____
Asthma?	No or Yes	_____
Poor Healing or Unsightly Scarring?	No or Yes	_____
Emphysema?	No or Yes	_____
High Blood Pressure?	No or Yes	_____
Heart Disease?	No or Yes	_____
Liver Disease?	No or Yes	_____
Kidney Disease?	No or Yes	_____
Skin Cancer?	No or Yes	_____
Melanoma?	No or Yes	_____

Are you currently Pregnant or Breast Feeding? Yes or No**List immediate family members that have been diagnosed with skin cancer:**

Has any family member been diagnosed with malignant melanoma?

No or Yes _____ Relationship: _____

Financial Policy

Payment is expected as services are rendered. We accept cash, checks, AMEX, VISA, and MasterCard. We also provide a 90 day interest-free credit through third-party financing upon request, and subject to qualification.

For those patients covered by insurance, we are happy to extend the courtesy of billing your insurance company for reimbursement to you. However, in order to provide this service to you, we must have complete insurance information. It is your responsibility to fill out the necessary forms that give us all the insurance information required.

For more extensive treatments if a pre-determination of insurance benefits is processed, you are then responsible for the co-payment at the time of service. If we do not receive payment from your insurance company within 30 days of billing them, the balance will become your responsibility. The insurance agreement is between you and your insurance company, and you will be expected to contact them directly if a problem arises. If you still have billing questions please call our office and ask for assistance.

For all accounts beyond 45 days with amounts due, there will be a \$10 billing fee or a financing charge of 1.5% per month, whichever is greater.

We assign all accounts over 120 days to a collection service for processing.

Sincerely,

Alan Rosenbach, M.D.

I understand that I will be charged \$50.00 if I fail to keep an appointment or if I do not notify the office of my cancellation by 3:00 p.m. the day before a scheduled appointment. I understand if my appt is for any laser procedure a 48 hour cancellation is required.

Should this account become past due, I agree to pay any reasonable additional fees, including any and all collection agency charges, legal fees and/or court costs, necessary to collect this account.

I agree to this financial policy, and I have read and received a copy of this document.

Signature _____

Date _____

Patient Name _____

Date _____

Patient Skin Care and Cosmetic Surgery

New technologies have expanded the range of products and procedures available to enhance the appearance of your skin and body. To help us provide you with services you desire and the best treatment possible, please answer the following questions regarding your skin care and cosmetic needs.

Skin Care

Please indicate which of the following concerns you may have about your general skin care needs. (check as many as apply)

- | | |
|--|---|
| <input type="checkbox"/> Acne Prone Skin | <input type="checkbox"/> Spider Veins |
| <input type="checkbox"/> Sunspots: Face, Arms and Chest | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Facial Vessels/Red Facial Discoloration | <input type="checkbox"/> Aging Skin |
| <input type="checkbox"/> General Skin Care (cleansing, moisturizing, etc.) | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Excess Facial/Body Hair | <input type="checkbox"/> Scar Treatment |
| <input type="checkbox"/> Other _____ | |

Skin Care & Cosmetic Services

The following is a list of the various services we provide to our patients. Please indicate the procedure(s) you would like to discuss with Dr. Rosenbach.

- | | |
|--|--|
| <input type="checkbox"/> Face, Neck and Chest Rejuvenation | <input type="checkbox"/> Hair Removal |
| <input type="checkbox"/> Facial Vessels/Red Facial Discoloration | <input type="checkbox"/> Schematic Botox |
| <input type="checkbox"/> Skin Resurfacing and Wrinkle Reduction | <input type="checkbox"/> Glycolic Peels |
| <input type="checkbox"/> Sunspots: Face, Arms and Chest | <input type="checkbox"/> Melanomography |
| <input type="checkbox"/> Scars and Stretch Marks | <input type="checkbox"/> Sclerotherapy |
| <input type="checkbox"/> Medical-Grade Microdermabrasion | <input type="checkbox"/> Mole Removal |