BEAUTIFUL SKIN
INSTITUTE

PATIENT INFORMATION as of _____ (Today's Date)

NAME: FIRST_____ MIDDLE__ LAST_____ DOB_____ GENDER ( ) F ( ) M

ADDRESS_____ CITY_____ STATE_____ ZIP_____

MOBILE_____ HOME PHONE_____ OFFICE PHONE_____

EMAIL _____

HOW WOULD YOU LIKE TO RECEIVE APPOINTMENT CONFIRMATIONS?
( ) Text ( ) Email ( ) Call

OKAY TO LEAVE MESSAGE ABOUT HEALTH INFORMATION AT (please circle any that apply):
( ) Mobile ( ) Home ( ) Office ( ) Email ( ) Patient Portal

EMERGENCY CONTACT

FIRST NAME:_____ LAST NAME:_____ Relationship:_____
MOBILE:_____ HOME PHONE:_____

I HEREBY GIVE MY PERMISSION TO DISCLOSE PERSONAL MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS:

( ) Same as Emergency Contact

NAME:_____ Relationship:_____ Mobile:_____ Home phone:_____
NAME:_____ Relationship:_____ Mobile:_____ Home phone:_____
NAME:_____ Relationship:_____ Mobile:_____ Home phone:_____

( ) I do **NOT** give permission to disclose personal medical information to family members or friends

PRIMARY CARE PHYSICIAN:_____
Address City State Zip Phone

REFERRING PHYSICIAN if different than Primary Care Physician:_____
Address City State Zip Phone

PLEASE TELL US ALL YOUR CONCERNS THAT BROUGHT YOU TO OUR OFFICE TODAY:

_____
_____
_____

LOCATION:_____
SYMPTOMS (e.g. itch, tenderness, pain, or bleeding):_____
CURRENT TREATMENT:_____
PRIOR TREATMENT:_____
PRIOR LAB (e.g. biopsy result):_____

DERMATOLOGIC HISTORY (please check):

( ) Acne
( ) Accutane Year:____
( ) Blistering sunburns #:___
( ) Cold sores/Herpes simplex
( ) Keloids/Hypertrophic scars
( ) Lupus
( ) Melasma
( ) Melanoma
( ) Other skin cancer Please specify:_____
( ) Rosacea
( ) Shingles
( ) Tanning bed use # of lifetime sessions:___
( ) Unusual moles

SKIN TYPE:
( ) Normal ( ) Dry ( ) Oily ( ) Combination ( ) Sensitive

PRODUCTS USED:
( ) CLEANSER: _____
( ) MOISTURIZER: _____
( ) SUNSCREEN: _____
( ) SELF-TANNING LOTION: _____

PLEASE CHECK THE BOX(ES) THAT BEST DESCRIBE(S) YOUR SKIN:
( ) Always burns, never tans ( ) Rarely burns, tans well
( ) Usually burns, then tans ( ) Very rarely burns, tans well, brown skin
( ) May burn, tans well ( ) Very rarely burns, tans well, very dark skin

MEDICAL HISTORY (please check):

( ) Anaphylaxis
( ) Antibiotics before going to dentist
( ) Artificial heart valve
( ) Bleeding tendency
( ) Defibrillator/Pacemaker
( ) Diabetes
( ) Fainting/Syncope
( ) Heart disease
( ) Hepatitis B or C
( ) High blood pressure
( ) HIV
( ) Joint replacement
( ) Transplanted organ

SOCIAL HISTORY (please check):

( ) Cigarettes #/day:___ #/years:___
( ) Second hand smoke
( ) Alcohol drinks/week:___

FAMILY HISTORY (please check):

( ) Melanoma
( ) Other skin cancer Please specify:_____
( ) Unusual moles

PLEASE LIST ANY PRESCRIPTION MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING

_____
_____
_____

DO YOU TAKE ANY OF THE FOLLOWING ON A DAILY BASIS?

( ) Fish oil ( ) Aspirin ( ) NSAIDs (Ibuprofen, Advil, Motrin, Aleve, Vioxx)
( ) Coumadin ( ) Eliquis ( ) Pradaxa ( ) Xarelto ( ) Other blood thinners
( ) Vitamin E ( ) Ginseng ( ) Gingko ( ) Biloba ( ) St. John's Wort

PLEASE LIST ALLERGIES OR SIDE EFFECTS TO ANY MEDICATIONS.

_____
_____

PLEASE LIST ANY OTHER ALLERGIES

( ) Adhesive tape ( ) Antibiotic ointment ( ) Iodine ( ) Latex ( ) Other:_____

LADIES: Are you currently pregnant or breastfeeding? ( ) Yes ( ) No Are you planning on becoming pregnant? ( ) Yes ( ) No

PHARMACY INFORMATION

In Network Dermatology Specialty Pharmacy. Many of our patients choose the additional service of an In Network Pharmacy. We do not own or receive any compensation from any pharmacy. We just want to help you get your medication quickly and as economically as possible.

In Network Pharmacy benefits include:
Automatic application of coupons that help reduce your prescription expenses. We believe that every patient should have access to essential dermatology medications for the lowest cost possible.
Insurance assistance and prior authorization services.
Shipping or delivery as a courtesy.

( ) Yes, please send prescriptions to the **In Network** pharmacy offering the best benefits.

( ) No, I would like to use the following pharmacy of my choice:

LOCAL Pharmacy:_____
Phone:_____
Address:_____

MAIL ORDER Pharmacy:_____
Phone:_____
Address:_____

If your health insurance does not cover your medication or mandates a prior authorization, we will send your prescription to the **In Network Pharmacy** providing you with the best benefits.

INSURANCE (if applicable)

Primary Health Insurance Company:_____ Ins. Phone:_____
Policy #:_____ Group #:_____
Insured:_____ DOB:_____ Relation:_____

Secondary Health Insurance Company:_____ Ins. Phone:_____
Policy #:_____ Group #:_____
Insured:_____ DOB:_____ Relation:_____

FINANCIAL RESPONSIBILITY POLICIES

Please familiarize yourself with your insurance policy & our policy below. We do not have access to particulars of your insurance plan. Thank you!

If we are unable to verify participation in your plan prior to your appointment or an insurance-required referral is not filed prior to your appointment, we will be happy to see you as a self-pay patient.

1. I understand my insurance company determines my **co-pay**, **co-insurance**, annual or out of network **deductibles**, **covered services** and financial responsibility. I understand I am responsible to take care of any amounts as determined by or not taken care by my carrier.
I am responsible for supplying accurate contact, credit card and current insurance information/card.
If my participation cannot be verified prior to a visit, I will pay for services rendered in full and personally submit a claim to my carrier.
Co-pays/balances are due prior to appointments.

2. **Does your insurance require a referral prior to treatment?** ( ) Yes ( ) No ( ) Not Applicable

Obtaining referrals is the responsibility of the patient. If required by my plan, I understand it is my responsibility to obtain a referral from my Primary Care Provider and present it prior to my visit as ***referrals cannot be backdated***.

Referrals must be provided before appointment or I will pay for services rendered in full and submit the claim to my carrier.
If a claim is denied due to missing or invalid referral (e.g. expiration date, exceeded number of visits, expired coverage), I am responsible for all applicable amounts for services/treatments.

3. If my insurance requires I meet an **annual deductible** before my healthcare is covered, I understand that I am responsible in full for services rendered in meeting those deductible requirements.

4. **For New Medical Patients** without insurance and patients who choose to go **Out of Network**; the office fee for the initial visit is $100 for cash pay patients. The office fee for a 1st time **Cosmetic Consultation** is $100 for cash pay patients. The cosmetic consultation fee covers your office visit and will be applied towards the first cosmetic treatment. Your investment cannot be refunded if no treatment is appropriate or chosen as your investment covers the consultation.

5. **24 Hour Cancellation Policy.** We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all patients including those on our waiting list, we ask for 24 hours prior notice to cancel/reschedule appointments.
Please notify us at hello@beautifulskin.institute or speak directly to a receptionist. We ask you to please do not leave a voice message. Please cancel Monday appointments by noon the previous Friday.
Without enough notice, missed appointments are preventing us from taking care of other patients who need treatment and can see us on time.
For patients who have either have been more than 15 minutes late or have not shown up, we schedule future appointments after the prepayment of a nonrefundable $100 deposit that will be applied towards the services rendered.

6. **Late Arrivals.** If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you will arrive, we will determine if there is enough time remaining to start your appointment. We may need to reschedule your appointment to another time to safely complete your assessment or treatment. Out of respect and consideration to other patients and also to us, please plan accordingly and be on time.
As a courtesy, we can typically see you the same day after the last patient.

7. ***Beautiful Skin Institute PLLC*** does not have a lab on premises. All specimens are sent to an independent lab that is frequently chosen by your insurance. Claims for specimens sent to a lab will be processed by that lab separately from the office visit with us. The patient is responsible to the lab for fees as per their insurance plan.

8. **Required Credit Card Information.** This required information is secured in our HIPAA compliant system. Once your insurance has paid their portion and notified us of your share, the remaining balance will be applied to your card.
This will not compromise your ability to dispute a charge or your insurance company's determination of payment.

I, the undersigned, authorize ***Beautiful Skin Institute PLLC*** to apply outstanding service balances / applicable fees to the account:

AMX MC Visa HAS Credit Card Number Exp. Date Billing Zip

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, have fully reviewed the HIPAA Notice of Privacy Practices available at www.beautifulskin.institute.

_____

Signature Date