

Today's Date:

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

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Nickname: \_\_\_\_\_

Gender:  Female  Male

Marital Status: S M D W O Spouse/Partner's Name: \_\_\_\_\_

SSN: \_\_\_\_\_ DL: State # \_\_\_\_\_

Home #: \_\_\_\_\_

Work #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

May we contact you by phone, mail or e-mail? Y N

Preferred Contact: Home Work Cell Other

Pharmacy:

Name : \_\_\_\_\_ Location: \_\_\_\_\_

Emergency Contact:

Relationship:

Number: Home:

Work:

Referral Source:

Referring MD:

Primary MD: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured SSN: \_\_\_\_\_

What is your chief concern today? \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Do you have any other concerns today: Circle all that apply  
rough spots, sores or new/changing mole, skin lumps or bumps, rashes, itching,  
varicose veins, athlete's foot

Other concerns: \_\_\_\_\_

Do you have any other skin condition: psoriasis, eczema, atypical moles, acne,  
rosacea, sun damaged skin, athlete's foot, toe nail fungus (please circle)

Do you have any history of precancerous spots? Y N

Do you have any personal history of skin cancer? Y N Type: \_\_\_\_\_

Any family history of malignant melanoma: (mother, father, siblings)? Y N \_\_\_\_\_

Any family history of: psoriasis severe acne (please circle)

Have you ever received radiation therapy? Y N \_\_\_\_\_

Do you have any brown birthmarks? Y N Location: \_\_\_\_\_

Do you have a history of cold sores? Y N Keloid scars? Y N Brown spots? Y N  
Melasma? Y N Shingles? Y N Shingles vaccine Y N

Do you have any medical problems? Please circle **Diabetes/ High blood pressure/ Hyperthyroidism/Hypothyroidism/ Iron deficiency/ Allergies/ Asthma/ Hay fever/ Anemia/ Depression/ Hepatitis/HIV Disease/Cancer**

Other medical problems: \_\_\_\_\_

Have you had any surgeries? Y N What were those surgeries? \_\_\_\_\_

**For female patients:** Are you pregnant? Y N Trying to get pregnant? Y N Breast Feeding? Y N Recent baby? Y N Age of onset of period: \_\_\_\_\_ Do you get a period every month? Y N Do you have any children? Y N

Do you have any history of the following? Please circle any that apply:  
Menopause/Irregular periods/ Infertility/ Nipple discharge/ Very heavy periods

**Skin type:** (circle all that apply) oily dry combination sensitive tough acne-prone rosacea prone wrinkled broken capillaries brown spots easy flushing and or blushing

**Current Skin Care:** Do you sunbathe? Y N Use a tanning salon? Y N Drive a convertible Y N Do you use sunscreen? Y N Name brand: \_\_\_\_\_ SPF: \_\_\_\_\_ Hat ? Y N Sunglasses Y N Protective Clothing? Y N

How much sun exposure have you had over your life: minimal moderate excessive

Do you work outdoors at the current time? Y N \_\_\_\_\_

Do have any outdoors hobbies? Y N \_\_\_\_\_

Have you ever had a blistering sun burn? Y N How many? \_\_\_\_\_

**Medications:** (please include all current treatments) including vitamins, minerals, supplements, homeopathic remedies, hormones, bleaching creams, hormone replacement therapies and birth control pills: \_\_\_\_\_

Do you take Vitamin D supplements? Y N How much? \_\_\_\_\_

Do you take an antibiotic before routine dental cleanings? Y N Why: \_\_\_\_\_

Are you allergic to any medications? Y N \_\_\_\_\_

What type of reactions: rash nausea diarrhea swelling wheezing shortness of breath hives

Are you allergic to latex? Y N local anesthesia? Y N Band-Aids? Y N Iodine? Y N

Are you slow to get numb with dental anesthesia? Y N

Do you ever faint when you get blood drawn or have a medical procedure performed? Y N

**Marital Status:** S M W D Do you have children: Y N How many?: \_\_\_\_\_

Grandchildren: Y N How many?: \_\_\_\_\_

**Education:** HS College Graduate school: \_\_\_\_\_

Occupation/job title : \_\_\_\_\_  
Dietary Restrictions: Y N \_\_\_\_\_  
Preferred language: \_\_\_\_\_ Any other fluent languages? \_\_\_\_\_  
Hobbies: \_\_\_\_\_ Do you smoke? Y N  
Do you consume alcohol? Y N How much? \_\_\_\_\_  
Use recreational drugs? Y N \_\_\_\_\_

**How does your skin respond to sunlight?**

<b>I Always burns, never tans</b>	<b>IV Rarely burns, tans easily</b>
<b>II Usually burns, does not tan well</b>	<b>V Rarely burns, tans profusely</b>
<b>III Sometimes burns, tans easily</b>	<b>VI Never burns, skin is dark</b>

**What color are your eyes:** blue brown green hazel

**Wt:** \_\_\_\_\_ **Ht:** \_\_\_\_\_

**How much sun damage have you noted on sun exposed areas:** none mild moderate severe

**Are you aware that our office offers cosmetic treatments?** Y N

**Are you interested in a complimentary skin care consultation to be educated about your skin type, skin care and skin treatments to improve the health and beauty of your skin?** Y N

**Are you interested in education re:**

- Care for your skin
- Microdermabrasion
- Lunch time peels
- Wrinkles
- Brown spots
- Broken blood vessels
- BOTOX®
- Fillers
- Laser treatments for sun damaged skin
- Laser resurfacing
- Treatment for excessive hair and laser hair removal
- Spider veins

# SONOMA SKIN POLICIES AGREEMENT

***\*Please Initial***

**PLEASE READ AND INITIAL THE STATEMENTS BELOW**

**Print Name:** \_\_\_\_\_

**FEES:** Our medical and surgical fees are based on the Medicare Fee Schedule for Sonoma County and are reviewed yearly. The fee associated with your visit is based on the complexity and duration of your consultation with the MD and for services rendered. There is typically a fee for each visit and/or service rendered. Fees for visits and services rendered are not refundable. \_\_\_\_\_ \*

**ARBITRATION:**

In the event a dispute shall arise between the parties to this agreement, it is hereby agreed that the dispute shall be referred for arbitration in accordance with the applicable United States Arbitration and Mediation Rules of Arbitration. The arbitrator's decision shall be final and legally binding and judgment may be entered thereon. Each party shall be responsible for its share of the arbitration fees in accordance with the applicable Rules of Arbitration. In the event a party fails to proceed with arbitration, unsuccessfully challenges the arbitrator's award, or fails to comply with the arbitrator's award, the other party is entitled to costs of suit, including a reasonable attorney's fee for having to compel arbitration or defend or enforce the award. \_\_\_\_\_ \*

**FOR PATIENTS WITH INSURANCE:** We accept Medicare, Marin IPA HMO and are a network provider for a variety of PPOs. Our contract with these insurance companies requires that your co-pay be paid by you. \_\_\_\_\_ \* And since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than you anticipated for care. **If an insurance carrier has not paid within 90 days of billing, professional fees are due and payable in full from you.** \_\_\_\_\_ \*

**FOR PATIENTS WITHOUT INSURANCE OR PLANS WE DO NOT ACCEPT OR FOR COSMETIC SERVICES:** Payment for service is due in full at the time service is provided in our office. \_\_\_\_\_ \* Please ask for an estimate of services before they are provided for you. For PPOs that we are not a preferred provider, we will give you a statement for services provided and you may submit it to your insurance company for re-imburement per your agreement with them. \_\_\_\_\_ \*

**SURGERY FEES:** All copays, deductibles, and payments for noncovered surgical procedures are due prior to your procedure. Prior authorization may be required by your carrier. \_\_\_\_\_ \*

**NONCOVERED SERVICES:** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. \_\_\_\_\_ \*

**YEARLY HEALTH CHECKS:** Periodic preventive health checks **may or may not be covered** under your health insurance policy; if they are not covered, you are responsible for charges incurred. \_\_\_\_\_ \*

**MISSED APPOINTMENTS:** In fairness to other patients and the office staff, we require at least 48 hours notice to cancel appointments. You **will be charged \$50 for missed medical appointments and \$125 for a missed surgery, cosmetic and laser appointment** \_\_\_\_\_ \*

**PAST DUE ACCOUNTS:** We do not have a payment plan for any of our services. We accept all major credit cards. **If we do not receive your payment within 2 billing cycles, your account will be referred to an outside billing & collections agency.** \_\_\_\_\_ \*

**ASSIGNMENT OF INSURANCE BENEFITS:** Please read and sign below:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Sonoma Laser, Skin & Surgery Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

**Please check one:** I have paid my insurance deductible for the calendar year \_\_\_\_\_ • Yes • No • Don't know

**THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION WHICH AFFECTS YOUR LEGAL RIGHTS AND MAY BE ENFORCED BY BOTH PARTIES.**

**I have read, understood, and agreed to the above policies.  
I understand that I am ultimately responsible for all professional fees.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For MEDICARE PATIENTS:** We will bill Medicare for you. All copayments or deductibles are due and payable at the time service is provided. \_\_\_\_\_\*

**For MEDICARE PATIENTS: SIGNATURE ON FILE:** I request payment of authorized Medicare benefits be made either to me or on my behalf to Sonoma Laser, Skin & Surgery Center for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature authorizes that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and **the patient is responsible only for the deductible, coinsurance, and non covered services.** Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

**I have read, understood, and agreed to the above policies.  
I understand that I am ultimately responsible for all professional fees.**

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HIPAA**  
**Health Insurance Portability & Accountability Act**  
**PATIENT ACKNOWLEDGEMENT & CONSENT FORM**

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge that you have read and or received a copy of our Privacy Practices and that you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

**The patient understands that:**

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

**This Consent was signed by:**

\_\_\_\_\_

Printed name of Patient or Representative

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient or Representative Signature

Date

Relationship to Patient  
(If other than patient)

\_\_\_\_\_

**My medical information may be shared with**

**(Please check one)**

- Emergency Contact**
- Spouse**
- Designate**

\_\_\_\_\_

Name of emergency contact, spouse or designate

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient signature

Date

**Witness:**

\_\_\_\_\_

Printed name of Practice Representative

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of Practice Representative

Date