Elite MD, Inc

Advanced Dermatology, Laser, and Plastic Surgery Institute

Date: ________________

Welcome To Our Office: Insurance Patient Registration Packet

Last Name: ______________________________ First Name: ______________________________ Middle Initial: _____

Date of Birth: ______/______/______ Age: _________ Sex: ☐ M ☐ F Social Security: ________-______-_________

Marital Status: ________________________ Spouse's/Guardian's Name: ____

Address: ____

City: ____ State: __________ Zip: ________________________

Home Phone: (_____) _____-________ Cell Phone: (_____) _____-________ Work Phone: (_____) _____-________

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work Email:____

If we need to reach you, may we leave confidential voicemail messages? ☐ Y ☐ N

Would you like to receive appointment reminders/promotions/complimentary treatments via email? ☐ Y ☐ N

To receive a text message for appointment reminders, please chose your Cell Phone Company:
☐ Alltel ☐ ATT ☐ Nextel ☐ Qwest ☐ Sprint ☐ T-Mobile ☐ Verizon ☐ Virgin Mobile ☐ Other

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To qualify for certain discounts, please let us know how you heard about us: Check as many as apply.

☐ My Physician – Name: _____________________ ☐ Insurance Plan – Name: ______________________
☐ Family/Friend – Name: _____________________ ☐ Other: ___________________________________
☐ Publication – Name: _______________________

Radio/Internet: ☐ Wolf 95.7 ☐ 1800MySurgeon ☐ Other: ________________________

Television: ☐ KRON 4 ☐ CBS 5 ☐ ABC/KGO 7 ☐ FOX/KTVU Show/Segment Name: _________________________

Occupation: ________________________________ Spouse/Guardian Occupation: _______________________________

If retired, previous occupation: _____________________________ Employer: __________________________________

Primary Physician: ____

Address: ____ Phone: (_____) _____-________

Medical Emergency Contacts:

Name: _____________________________________Relation: _______________________ Phone: (_____) _____-________
Name: Relation: Phone: ( ) -

Patient Name: _______________________________ Date of Birth: ______________

Health Insurance Information:

Date: ________________

Please read these instructions before filling out this form.

- Section A and B must be filled out, even if a copy of your insurance card has been provided to us.
- Please ensure we have a copy of your insurance card(s) and driver's license to qualify you for insurance benefits.
- If you are a Medicare patient, please skip to Section C. This section must be filled out.

A. Primary Insurance Name:

Name of Patient: _______________________________________ Insurance Name: ______________________

Name of Insured (if different from above): _______________________________________

Relationship to Patient: □ Parent □ Spouse □ Self □ Other ________ Insurance ID: ___________________

Employer/Group Name: _______________________________________ Group #: _______________________

Co pay Amount: $____________ Co pay for Generics $____________ Brand $____________

Do you have a drug plan? □ Y □ N Phone # for Insurance Company: (_____) _____-________

B. Secondary Insurance Name:

Name of Patient: _______________________________________ Insurance Name: ______________________

Name of Insured (if different from above): _______________________________________

Relationship to Patient: □ Parent □ Spouse □ Self □ Other ________ Insurance ID: ___________________

Employer/Group Name: _______________________________________ Group #: _______________________

Co pay Amount: $____________ Co pay for Generics $____________ Brand $____________

Do you have a drug plan? □ Y □ N Phone # for Insurance Company: (_____) _____-________

C. Medicare:

Do you have Medicare? □ Y □ N Is Medicare your primary insurance □ Y □ N

Do you have: Part A? □ Y □ N Effective Date __________

Do you have: Part B? □ Y □ N Effective Date __________

Do you have: Part D? □ Y □ N Effective Date __________

Do you have supplemental insurance to Medicare? □ Y □ N - If Yes, please complete Section B above.

Patient Name: ________________________________ Date of Birth: ______________

Patient Medical History

Date: _______________

Reason for Today's Visit? ____

We strongly recommend a full skin cancer screen on your initial visit and once a year. Would you like one? □ Y □ N

When is the last time you visited a dermatologist (Who?)____

Allergies (Novocain? Penicillin? Latex?Please mention reaction): ____

Current Medications (including topical creams, over-the-counter, herbals,etc): ________________________________

____

Surgeries (including Cosmetic Surgery): ____

Any Personal History of:		**Any Family History?**
Acne?	□ Y □ N	□ Y □ N
Asthma?	□ Y □ N	□ Y □ N
Hay Fever?	□ Y □ N	□ Y □ N
Eczema?	□ Y □ N	□ Y □ N
Psoriasis?	□ Y □ N	□ Y □ N
Sunburns?	□ Y □ N	
How Many? ____________________		
Do you:	□Burn □Tan □Both	
Skin Cancer?	□ Y □ N	□ Y □ N
Type/When: ____________________		
Melanoma:	□ Y □ N	□ Y □ N
Location/Year:_________________		
Radiation Therapy?	□ Y □ N	
For What? _____________________		
Cold Sores?	□ Y □ N	
Keloid/Enlarged Scars	□ Y □ N	□ Y □ N
Poor Healing?	□ Y □ N	
Hyperpigmentation?	□ Y □ N	
Use of Blood Thinners?	□ Y □ N	
Type: _________________________		
Use of Accutane?	□ Y □ N	
When: ________________________		
Pacemaker?	□ Y □ N	
Fainting Episodes?	□ Y □ N	
HIV/AIDS?	□ Y □ N	

Any Personal History of:

Cancer?	□ Y □ N
Type: ________________________________	
Diabetes?	□ Y □ N
Autoimmune Disease?	□ Y □ N
Thyroid Disease?	□ Y □ N
Arthritis?	□ Y □ N
Leg Swelling?	□ Y □ N
Migraines?	□ Y □ N
Gastrointestinal Disease?	□ Y □ N
Heart Disease?	□ Y □ N
Hepatitis?	□ Y □ N
Lung Disease?	□ Y □ N
Seizures?	□ Y □ N
Glaucoma?	□ Y □ N
Other? ________________________________	

Social History

Are you pregnant?	□ Y □ N
Do you smoke?	□ Y □ N
How much? ____________________________	
Do you drink?	□ Y □ N
How often?	
Do you use drugs?	□ Y □ N

Any other pertinent information?____________

____

Height: ______________ Weight: ____________

Any Cosmetic Concerns? ____

Other Skin Problems (explain) ____

Patient Name: _________________________ Date of Birth: ______________

Cosmetic Interest Questionnaire

Date: __________________

Dear Valued Client/Patient,

Thank you for choosing Elite MD – Advanced Dermatology, Laser, and Plastic Surgery Institute. We are a premier and state-of-the-art center, which offers the latest procedures and technologies to provide you with the most comprehensive and individualized care. Our website, www.elitemdspa.com, features before and after photographs, upcoming events, medical articles and featured quotes and interviews by our renowned and unique team of physicians, who personally perform all medical/surgical procedures. Our team is often selected to participate in clinical research trials and is a national training center for selected cosmetic procedures. Check the skin care services that you are interested in.

Skin/Body Problems:

□ Acne/Acne Scarring
□ Rosacea (red cheeks)
□ Aging Skin
□ Lines, Wrinkles
□ Skin Texture
□ Hyperpigmentation
□ Enlarged Pore Size
□ Sun Damage (brown/age spots)
□ Hair Growth
□ Spider Veins (face/legs)
□ General Skin Health
□ Skin Care (moisturizers, sunscreens)
□ Body Contouring
□ Fat reduction
□ Breast contouring
□ Sagging skin from pregnancy or weight loss
□ Underarm Sweating
□ Stress and Nutrition
□ Other _______________________________

Skin/Body Solutions:

□ Medical Acne Treatment
□ Laser Hair Removal
□ Liposuction/Laser Liposuction
□ Botox
□ Cosmetic Filler (Restylane/Juvederm/ Radiesse/Fat Injections)
□ Medical Grade Skin Care
□ Laser Photorejuvenation
□ Facials/Microdermabrasion/Peels
□ Sclerotherapy
□ Laser Vein Removal
□ Laser Skin Tightening
□ Tummy Tuck
□ Facelift/Necklift
□ Blepharoplasty
□ Breast reduction/lift/augmentation
□ Stress Reduction/Nutrition Counseling
□ Mole Removal
□ Other _______________________________

Would you like to have a complimentary skin care evaluation/lifestyle analysis? □ Y □ N
Would you like to schedule a cosmetic consultation with our physicians? □ Y □ N

Are you interested in being selected to participate in clinical trials or national training (selected procedures may be discounted or complimentary)? If so, please list your email to place into our database:_____________________________

Please list your current skin care regimen:

AM: Cleanser: ________________________
Day Cream: ______________________
Sunscreen: _______________________

PM: Cleanser: ______________________
Night Cream: _______________________
Prescription: ________________________

Financial and Miscellaneous Policies of Elite MD, Inc

1. **Insurance Patients - PPO/HMO/Medicare:**
   a. We are required to make a copy of your insurance and driver's license.
   b. If your insurance requires a referral/authorization from your primary care physician (PCP), you must present your authorization prior to your exam. If you are unable to provide us with your authorization, we will gladly contact your PCP for you, or if he/she is unavailable, will reschedule your appointment for a time that is convenient for you.
   c. You will be responsible for services denied by your insurance or for any balances that remain after insurance coverage is applied. Please be aware of your deductible (if any), as you are responsible for any remaining balances.
   d. If you are unable to provide your insurance information or we are unable to confirm your insurance status, you will be treated as a Private Pay Patient (PPP) at the time of your visit and you will be responsible for payment at the time of service (please see Section 3 below). After your insurance has been verified, we will refund the difference to you.
2. **Co-Pays:**
   a. All co-pays are due at the time of the visit. Our co-pay fee is $25 if you are a patient who is unaware of your co-pay amount or if the co-pay amount is not stated on your insurance card. If your co-pay if determined to be less than $25, Elite MD will gladly refund you the difference. If the co-pay amount is greater than $25, Elite MD will bill the balance to you through our billing service. Co-pays cannot be waived as we are a contracted provider.
   b. If your copay is not paid at the time of the visit, you will be assessed a $20 surcharge.
   c. There may be an additional co-share amount billed to you if the doctor performs a procedure.
3. **Self/Private Pay Patients:**
   a. If we are not contracted with your insurance, or you do not have insurance, you are responsible for payment at the time of service. As a professional courtesy, we will submit claims to your insurance, but you will be responsible for any services that are denied.
4. **Surgical Patients:**
   a. We require patients to place a $1000.00 deposit to hold their surgery. This deposit is completely non-refundable.
   b. Payment of surgery is due in full 2 weeks prior to the surgery date. If full payment is not received by the date, the surgery will be cancelled, and the deposit will be deemed non-refundable. If your surgery is within 2 weeks of your consultation, then payment is due in full at time of surgery scheduling.
5. **Refund Policy/Cancellation Policy/Returned Checks/Collections:**
   a. No refunds for medical or cosmetic procedures. Exchange or refund for products within 14 days of purchase. Prescription products are not refundable or returnable.
   b. To avoid $50 fee, please call 24 hours in advanced to cancel or re-schedule your appointment.
   c. A charge of $30 will be made for all returned checks.
   d. In the event that any action is brought to collection, you agree to pay any reasonable collection costs and/or fees and interest. All accounts are subject to a finance charge in not paid within 30 days of billing date. The finance charge is computed by a periodic rate of 1.5% per month, which is an annual percentage rate applied to current balance.
6. **Assignment and Release of Insurance Benefits:**
   a. I hereby assign my insurance benefits to be paid directly to Elite MD, Inc., and authorize Elite MD to release my insurance and any information required to process claims for services rendered. I understand if claims are denied due to any reason, I will assume full responsibility for all charges incurred by me and all dependents. Additionally, I will be financially responsible for any non-covered benefits, deductibles, or any co-payments for services, which have been provided to me. This assignment will remain in effect until revoked by me in writing.
7. **Educational Photography:**
   a. I consent to be photographed before and after treatment and these photos are the property of Elite MD.
   b. I give permission for medical photography to be taken and they may be used for educational purposes such as teaching and academic works. I may chose to opt out of Section 7, Clause B by initialing here:_______

All information I have filled out is correct. My signature indicates my understanding/responsibility for all statements on this page. A copy/scan of this page is considered to be as valid as the original. Date: ____________________

Date of Birth: Printed Name: Signature:

HIPAA/Communication Consent Form:
Patient Consent for Use and Disclosure of Protected Health Information

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our clients review and sign this Communication Consent Form.

Elite MD will not release confidential and/or other Protected Health Information (PHI) by home mailing, home telephone, answering machine, work telephone, voice mail, cell phone and or/email. When we place telephone calls and an answering machine responds, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If I do not sign this consent, Elite MD Inc may decline to provide treatment to me.

I, ______________________________________ authorize Elite MD to contact me and or named authorized person(s) and to convey PHI by the following methods and assume responsibility to notify Elite MD whenever this information changes:

Cell Phone	____Yes	____No	Home Telephone	____Yes	____No
Work Telephone	____Yes	____No	Email	____Yes	____No
Home Mailing	____Yes	____No	Fax	____Yes	____No
Answering Machine	____Yes	____No	Voice Mail	____Yes	____No

List names of other people/physicians authorized to receive information about your care:

Spouse: __________________________________ Parent: __________________________________

Friend: __________________________________ Other: __________________________________

I also understand that Elite MD will release PHI to the individual entrusted to my post-surgical care, specifically the individual responsible for my transportation after my surgery. I may chose to opt out by initialing here:____

This authorization will remain valid unless revoked by the patient or legal guardian. This authorization applies for all episodes of care and treatment. The authorization applies to all medical information physically or electronically stored at any office/location of Elite MD, Inc.

Patient Printed Name: ____ Date of Birth:_________________

Date: _____________ Patient Signature: ____

Parent/Guardian Signature (as needed): ____

Witness/Physician Signature: ____ Date:__________________

Instructions for Exam Room:

- Please turn off cell phones and pagers when leaving waiting room and remove chewing gum/candy/mints prior to the exam.
- If it is your initial visit with the doctors, you may receive a full skin exam. Remove all clothing (including shoes/socks). Leave on underwear and bra, and put on a gown leaving the back open. Please place clothing on chair, not on counter.
- If you have a hand rash, please also take off shoes/socks.
- If undergoing cosmetic treatments on the face, please take off facial make-up prior to examination. If undergoing laser hair removal, be sure the area has been shaved within 24 hrs.