PATIENT INFORMATION

Last Name ______ First Name ______ Middle Initial ______ Marital Status ______

Street Address ______ City ______ State ______ Zip Code ______

Cell Phone ______ Home phone ______ Email Address ______

Preferred Method of Contact (circle all that apply): Cell Home Text Email Best time to contact: AM PM

I give permission for Dr. Friedman's office to leave detailed messages (voice or text) that may include test results on: Cell and or Home phone (circle preference) __________ Patient initials

If you would like to receive appointment reminders by text message, please provide us with you cell number and send CSVMI via text to 622622 (message rates may apply. Text HELP to 622622 for help or STOP to 622622 to opt out)

___/___/___ Date of Birth ______ Age ___/___/___ Social Security Number Please circle: Male Female

Emergency Contact ______ Relationship ______ Phone number ______

I give permission to the following to have unlimited access to my medical records, appointment information and billing information at Dr. Friedman's office. I understand that at any time, I may remove names from this list. This agreement is valid for a period of one year from the date of my signature.

| Name | Relationship | Phone |
|---|---|---|
| | | |
| | | |

**Please note that we are required by federal mandate to ask the following questions. We apologize to any patient that is offended by the questions below. Please circle or specify your responses:**

**Decline to answer**

**Race** African American Asian Caucasian Other ______

**Ethnicity:** Hispanic or Latino Non-Hispanic or Latino Other______

**Preferred Language:** English Spanish Other ______

**PRIVACY NOTICE ACKNOWLEDGEMENT**

I have received a copy of Cosmetic Dermatology & Vein Center's Notice of Privacy Practices.

Signature ______ Date ______

## MEDICAL HISTORY

Patient: ______________________________ M___ F___ Married/Single AGE______

Reason for today's visit: ______________________________
How long has condition been present: ______________________________
Have you been treated for this before? [ ] Yes [ ] No When (approximately)?______________
Are you allergic to any medications? [ ] Yes [ ] No If yes please list: ______________

______________________________

List all medications you are currently taking including birth control, vitamins and social drugs:

______________ ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

**Do you have now, or have you ever had diseases or conditions related to: (please check all that apply)**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| | | Allergies, environmental | | | Chest pain, palpitations | | | Hormonal, diabetes, thyriod |
| | | Allergies, medication | | | Stomach pain, dark stool, | | | Irregular menstrual cycles |
| | | Allergies, tape-adhesives | | | Painful or frequent urination | | | Skin lesions or rash |
| | | Weight loss, fatigue, fevers | | | Bruising or painful lumps | | | Immunologic |
| | | Eye problems,visual changes | | | Weakness or headaches | | | Cancers |
| | | Problems hearing,sore throat | | | Depression or anxiety | | | Poor healing (scarring/long healing) |
| | | Breathing problems, cough | | | Bone or joint pain, muscle aches | | | Surgery |

**An unchecked box indicates that you do not; nor have ever had a disease or condition related to the above**

IF YES TO ANY ABOVE, PLEASE EXPLAIN: ______________________________

______________________________

PERSONAL HISTORY OF MELANOMA OR OTHER SKIN CONDITION: [ ] YES [ ] NO (IF YES, PLEASE EXPLAIN)

______________________________

Do you have a history of: multiple sunburns or significant sun exposure associated with work/recreation [ ] Yes [ ] No
When you are exposed to the sun, do you: [ ] Tan only [ ] Tan and burn [ ] Burn
Occupation: ______________________________
Do you drink alcohol? [ ] Yes [ ] No Do you smoke? [ ] Yes [ ] No
Have you had or have you been exposed to HIV (AIDS), sexually transmitted diseases or Hepatitis? [ ] Yes [ ] No
Have you ever had dental anesthesia (Novocaine)? [ ] Yes [ ] No Any bad reaction [ ] Yes [ ] No
List any other disease or condition we should know about ______________________________
**(Women) Are you pregnant, breast feeding or considering having children within the next year? [ ] Yes [ ] No**

FAMILY HISTORY (IF YES, PLEASE GIVE RELATIONSHIP)
Any family history of melanoma? [ ] Yes [ ] No Other types of skin cancers? [ ] Yes [ ] No (IF YES, PLEASE EXPLAIN)

______________________________

Other types of cancer? [ ] Yes [ ] No Other conditions or skin diseases [ ] Yes [ ] No (IF YES, PLEASE EXPLAIN)

______________________________

Patient/guardian Signature: ______________________________ Date: __________

Physician Signature: ______________________________ Date: __________

# COSMETIC DERMATOLOGY & VEIN CENTERS
**Scott Friedman, D.O.**

## INSURANCE VERIFICATION FORM

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## ALL OTHER INSURANCE

Patient's or Authorized Person's Signature:

I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance benefits either to myself or the physician who accepts assignment.

Signature of the Insured or Authorized Person ______________________ Date ______________

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## MEDICARE AND SUPPLEMENT INSURANCE

This form is required to keep your signature on file, authorizing us to file claims to Medicare for you and to release information that the payer requires for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me, to release to the Social Security Administration and Health Care Financing Administration (or its intermediaries or carriers) any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits only apply.

Signature as it appears on Medicare Card ______________________ Date ______________

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If you have a supplement policy and it is a Medigap policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file.

I request authorized Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Medigap carrier any information needed to determine these benefits for the benefits payable for related services.

Signature as it appears on Medicare Card ______________________ Date ______________

## Cosmetic Dermatology & Vein Centers Financial Policy

Thank you for choosing Cosmetic Dermatology & Vein Centers as your skin care provider. We are committed to your care and the success of your treatment. The following is our financial policy. If you have not been seen by a physician in our offices in the past 3 years, you ae considered a new patient and will be billed accordingly. Please read our financial policy carefully and sign prior to your treatment.

Please note that due to HIPAA (Health Insurance Portability and Accountability Act) and other federal regulations, we require that you review our financial policy prior to signing it.

**Patient or Guardian Initials:** ___________ **Date:** _______________________

**Insurance**

It is our policy, and insurance regulates, there may be separate charges for each condition that is treated. Dr. Friedman participates in most insurance plans and we will submit claims to your insurance carrier for covered medical services. Dr. Friedman accepts what your insurance allows as payment in full. This means that you are only responsible for non-covered services, deductibles, and/or co-pays. If you policy has a co-pay for services or if you are in doubt as to whether your treatment is a covered benefit, please inquire prior to you receiving treatment and incurring any charges. Due to the rapid changes in insurance company policy and privacy regulations, it is not always possible for us to accurately obtain or confirm your benefits, deductibles, or co-pays. It is ultimately your responsibility to be aware of your contract benefits. It is not our policy to routinely quote prices, however, if it is of concern, the staff will be happy to answer any billing questions you may have.

**Patient or Guardian Initials:** ___________ **Date:** _______________________

**Cosmetic Procedures**

Fees for cosmetic procedures are quoted at your consultation with our staff. Your insurance carrier does not cover fees for cosmetic services and payment is required prior to services rendered.

**Minor Patients**

A minor patient is required to be accompanies by a parent or legal guardian for treatment. If you minor child continues care and we are unable to accommodate your schedule, please consult with a staff member to make arrangements for us to treat your minor child.

**Payment**

We accept cash, personal checks, Care Credit, and MasterCard or Visa for payment. To avoid any disappointment or misunderstanding, if you are concerned about your charges for treatment, please inquire prior to receiving treatment and incurring charges. **Co-pays are due in full on the date of service.**

A 1.5% per month late fee will apply on the amount of any account 30 days overdue. There is a $25.00 fee charged for any returned check (this amount may vary depending on what our bank charges us for your returned check). We reserve the right to charge for missed appointments and associated costs.

**I have read and understand the above Financial Policy. I accept and agree to the terms outlined herein and agree to the treatment by Dr. Friedman and/or his assistants. The policy shall remain in effect until revoked in writing by the undersigned responsible party.**

**Patient or Guardian Initials:** ___________ **Date:** _______________________