ADVANCED DERMATOLOGY
and LASER INSTITUTE of SEATTLE
MEDICAL and COSMETIC SKIN CARE

## INTRODUCTIONS

"Legal" Name _____Preferred Name _____Today's Date_____
Address _____City/State/Zip_____
Phone - H( __ ) W( __ )_____Cell (____)_____
Email _____
Birth date _____Age___ Sex: M/F Pronouns:_____Marital Status: Married □ Single □ Widowed □
Partner/significant other □ Employer _____ Job title? _____
*Students* - Please provide family's address for billing_____
**Emergency Contact Person:_____ Best # to reach them _____**
**Relationship to patient:_____**

**** Students & dependents – Please list below the person who holds the insurance, ie, father, mother, spouse (legal Name)****

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| **Primary Insurance Coverage** | **Secondary Insurance Coverage** |
|---|---|
| Insured Name _____ | _____ |
| Insurance Co. Name_____ | _____ |
| Insurance Co. Address _____ | _____ |
| City/ State/ Zip_____ | _____ |
| Subscriber ID #_____ | Subscriber ID #_____ |
| Group # _____SS#____ - ____ - _____ | Group # _____SS#____ - ____ - _____ |
| Birth date _____ | Birth date_____ |
| Employer_____ | Employer_____ |

**Acknowledgement:**
To the best of my knowledge, the above information is correct. I will inform this office of any changes in medical coverage, and general information provided above. I acknowledge that not all services provided in this office are covered by medical insurance. It is my responsibility to educate myself on the insurance plan I have chosen and I am ultimately responsible for all charges.

**Cancellation Policy:** If you cannot keep your appointment, you are expected to contact our office during regular office hours with at least 2 business days notice. Our regular business hours are Monday through Friday 8 am-5 pm. Appointments canceled without 2 business days notice, and complete "no-show" appointments will lead to you being charged $150 per occurrence. Additionally, patients who repeatedly miss their appointments may be subject to paying a deposit upon rescheduling thier appointment or dismissal from future care by this office. There are no exceptions.

**Medical Records:** I understand that photographs are required to be taken periodically throughout my medical and cosmetic treatments to document my initial presenting skin issues and to effectively monitor and compare initial skin presentations with changes made over time. These photographs become part of my medical records but are kept proprietary. I hereby consent with my signature below to have photographs taken for the above reasons and to be kept proprietary in my patient records.

**Patient Signature_____ Date _____**
(Parent or guardian if patient is a minor)

# HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name:_____ Date of Birth:_____

**Notice of Privacy Practices:**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) I give permission for DETAILED telephone messages regarding protected health information to be left at the following numbers:

Check all that apply and WRITE DOWN the applicable number on the line provided

_____ Home Phone (Including voicemail/answering machine)

_____

_____ Cell Phone (including voicemail):

_____

_____ Other Phone (Type: _____ - IE Work, Mother, etc)

_____

# FINANCIAL POLICY

**All patients must accept this policy before receiving treatment.**

We are pleased you have chosen Advanced Dermatology and Laser Institute of Seattle for your health care and aesthetic needs. There are unforeseen times that an aesthetic patient will be treated for a medically related dermatology concern and billed as such therefore the policies are combined.

1. Advanced Dermatology and Laser Institute files insurance claims for patients as a courtesy. Regardless if you have an insurance plan, you still have full responsibility for payment of the bill. It is also the patient's responsibility to know if the physician he or she is seeing is a participating provider with his/her health plan.
2. Co-payments are always due at the time of service. Our contractual agreement with your carrier prevents us from waiving your required co-pay amount.
3. The "patient balance" is due within 15 days of the statement date unless you have made other arrangements with the billing office. A Finance Charge is added to any outstanding balance at 12% per Annum (1% Monthly). We will collect all outstanding patient balances prior to each visit.
4. If you have no insurance coverage or are receiving aesthetic services, payment is due at time of service.
5. We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.
6. Patients are allowed 30 days after the date of purchase of any product, for a full refund, the unused portion must be returned. Services are not refundable. In the event that only part of a service package is used, the remaining services will not be refunded but rather transferred as different services. For the treatment of minors, we hold parents or legal guardians responsible for any uncovered charges at time of service.
7. A $40.00 service charge will be assessed for returned checks.
8. Laboratory Services – if you have blood or specimens obtained will be billed separately by the laboratory that conducts the test(s). If your insurance company requires a specific laboratory for the processing of your blood work, it is your responsibility to notify the clinical staff at the time of the blood draw. You are responsible for all laboratory fees.
9. Please call US Providers directly at (206) 453-1818 to correct any billing errors promptly. If you ignore the billing statements or telephone calls, they will assume that you do not intend to pay for the services that were provided in good faith. At that time your account will be forwarded to an outside collection agency.
10. Referrals – some insurance plans require that a referral from the primary care physician be obtained prior to being seen. It is the responsibility of the patient to obtain this referral. We are not responsible for costs associated with referrals to other providers, including laboratory, pharmacy, imaging, hospital, etc.
11. Personal Injury – we will not be a party to any litigation suits filed for personal injuries. We require payment in full at time of service and any payment from litigation is to be sought by you for reimbursement.
12. Work Related Injuries – pre-authorizations for care is the responsibility of the patient. If the prior authorization is not obtained, you are responsible for full payment at the time of service. If your workers compensation carrier has not paid your account within 45 days of the date of service, the owed balance will become the responsibility of the patient.
13. Disputes to charges – The patient or responsible party will be responsible for all attorney fees accrued if they were to file suit against Advanced Dermatology and Laser Institute of Seattle.

Print Responsible Party Name: _____Relationship:_____

Responsible Party Signature:_____Date:_____

## Release of Information Policy:

Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under Worker's Compensation.

If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

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**Disclosures to Friends and/or Family Members:**

*Do you want to designate a family member or other individual with whom the provider and his staff may discuss your medical condition?*

**_____(Patient initials) I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:**

**Name:_____ Relationship:_____**

**Contact Number: _____**

**By signing below, I hereby permit the physicians or other health professionals at Advanced Dermatology & Laser Institute of Seattle involved in my treatment to release healthcare information for purposes of treatment or healthcare operations as described in the above privacy notice. Please sign as acknowledgment of the policy even if there is no person assigned to this policy.**

**Patient Name (Printed):_____**

**Patient Signature:_____Date: _____**

**MEDICAL HISTORY** **Patient Name**_____

Primary Care Provider Name & Phone number:_____

Date of last flu shot: _____; Date of last pneumonia Vaccine? _____

Date of last Colonoscopy; _____ what is your BMI? _____

Have you ever been screened for Clinical Depression? Yes ☐ No ☐ Date:_____

Do you currently use any **tobacco** products? Yes ☐ No ☐ – If former smoker, how long ago did you stop?_____

Type of tobacco product _____How much per day _____For how long_____

**Alcohol** drinks per week_____

***WOMEN***: Are you **pregnant**? No □ Yes □ Month due? _____ Are you **nursing**? No □ Yes □

Are you on **birth control**? No □ Yes □ Type:___ Are you going or gone through menopause? No □ Yes □

Have you ever been screened for Osteoporosis? Date:_____ Urinary Incontinence? Date:_____

Date of last Mammogram:_____

**PLEASE MARK PAST AND PRESENT CONDITIONS:**

| | | | |
|---|---|---|---|
| □ Anxiety | □ COPD | □ Hearing Loss | □ Mitral Valve Prolapse |
| □ Arthritis | □ Depression | □ Heart Murmur | □ Numbness or Tingling |
| □ Atrial fibrillation | □ Diabetes | □ Hepatitis A, B, or C | □ Pacemaker |
| □ Artificial Heart Valve | □ Drug or Alcohol Abuse | □ HIV Positive or AIDS | □ Radiation Therapy |
| □ Artificial Joints | □ Epilepsy or seizures | □ High Blood Pressure | □ Sinus Trouble |
| □ Artificial Other_____ | □ Fainting or Dizzy | □ Low Blood Pressure | □ Stroke |
| □ Asthma | Spells | □ Leukemia | □ Thyroid Disease |
| □ Bleeding Disorders | □ Glaucoma | □ Lymphoma | □ Tuberculosis |
| □ Chemotherapy | □ Seasonal Allergies | □ Kidney Disease | |

□ Cancer or Cancer Treatment please describe:_____

Previous Surgeries – please describe:_____

**RACE / ETHNICITY:** Circle all that apply: Caucasian, Black/African American, Asian, American Indian, Native Hawaiian, Pacific Islander, Hispanic Latino, other_____

**SKIN HISTORY (MARK ALL THAT APPLY)**

| | | | |
|---|---|---|---|
| □ Acne | □ Psoriasis | □ Asthma | □ Dry Skin |
| □ Eczema | □ Hay Fever | □ Melanoma | □ Contact Dermatitis |
| □ Flaking/itching scalp | □ Blistering Sunburns | □ Precancerous Moles | □ Actinic Keratoses |
| □ Skin Rash/Hives | □ Basal Cell Carcinoma | □ Squamous Cell Carcinoma | □ Other _____ |

Do you have a family history of **Melanoma**? Yes □ No □, if yes, relative(s)?_____

Other family history of **skin cancer**? Yes □ No □, – if yes, please describe_____

_____

Do you wear **sunscreen**? Yes □ No □, *what SPF*?_____How often do go outdoors w/o sunscreen? _____

Do you tan in a tanning salon? Yes □ No □, Have you in the past? Yes □ No □

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?**

| | | | |
|---|---|---|---|
| ☐ Erythromycin | ☐Local | ☐Penicillin | ☐ Sulfa |
| ☐ Latex | ☐Anesthetics | ☐ Other _____ | ☐ Tetracycline |

**** Pharmacy - Name & number** _____

**Please list "ALL" Prescription and Herbal medications & Vitamins/Supplements that you are currently taking**

_____

_____

Do you take a **Daily Aspirin**? Yes □ No □ *Dose*_____ *Do you use **Anti-infammatories**?* Yes □ No □ *dose*_____

**Patient Signature** _____ ___ **Date** _____

(Parent or guardian if patient is a minor)

## GETTING TO KNOW YOU

**Patients Name_____ _____Date_____**

Please describe your long term goals for the health of your skin_____

_____

What is your current skin care regimen?_____

Do you have **fine lines** and **wrinkles**? Yes ☐ No ☐

Are you experiencing **sagging** or **drooping** of the skin? Yes ☐ No ☐

Do you have **sun spots** or **discoloration** on your face or body? Yes ☐ No ☐ Where_____

Do you have any **stretch marks**? Yes ☐ No ☐, if yes - where_____

Do you have any **scars or keloids** from past surgical procedures or trauma events? Yes ☐ No ☐,
Please describe_____

Are you experiencing **hair loss /thinning**? Yes ☐ No ☐

Want information on better hair products - Yes ☐ No ☐

Want information on great supplements - Yes ☐ No ☐

Want information on hair restoration - Yes ☐ No ☐

Would you like longer, fuller, **Eyelashes** or eyebrows? Yes ☐ No ☐

Want information on Latisse - eyelash grow system - Yes ☐ No ☐

Is there anything you would like to change about your face or body?_____

_____

**Check any of the following Laser Treatments you are interested in or would like more information about:**

- ☐ Acne scaring
- ☐ Fine Lines & Wrinkles
- ☐ Enlarged facial pores
- ☐ Sun damage/age spots
- ☐ Brown spots
- ☐ Skin Texture
- ☐ Youthful looking skin tone
- ☐ Skin Tightening
- ☐ Skin rejuvenation
- ☐ **"Three for Me Laser Therapy" using the 1540 and Max G Laser – Targets: All the above issues; treatment consists of 3-4 visits set 1 month apart.**

- ☐ Rosacea
- ☐ Facial Veins
- ☐ Broken blood vessels
- ☐ Pigmentation
- ☐ Red spots
- ☐ Spider Veins legs
- ☐ Hair Removal
- ☐ Actinic Keratosis
- ☐ Stretch Marks
- ☐ Scars
- ☐ Melasma
- ☐ Nail Fungus
- ☐ Skin Tightening

**Check any of the following treatments or services you are interested in or would like more information about:**

- ☐ Fillers
- ☐ Medical Grade facials
- ☐ Micro needling-reduce acnes scars & skin rejuvenation
- ☐ Neuromodulators (eg. Botox)
- ☐ Kybella for removal of double chin
- ☐ Chemical Peels-exfoliation & skin resurfacing