SKIN&VEIN MICHIGAN
DERMATOLOGY • COSMETIC SURGERY

PATIENT REGISTRATION & MEDICAL HISTORY **DATE**_____

PATIENT INFORMATION

Name _____ **SS#**_____
LAST FIRST MIDDLE

Birthdate _____ **Gender** ❑ Male ❑ Female **Marital Status** ❑ Single ❑Married ❑Divorced ❑Widowed

Address 1 _____ **City**_____ **State** _____ **Zip**_____

Address 2 _____ **City**_____ **State** _____ **Zip**_____

Phone *(check ☑ preferred contact number)*: **Home** ❑ _____ **Cell**❑_____ **Work**❑ _____

e-Mail _____ **May we send information to you at this email address?** ❑ Yes ❑ No
We promise never to share, trade, sell, or market your email address

Employer _____ **Occupation** _____

Referring Physician ❑PCP or ❑Other Physician Name_____ Phone _____

If not referred, how did you hear about us? ❑Website ❑Physician _____ ❑ E-Newsletter ❑ Current Patient ❑Other _____

Pharmacy _____ **Address**_____
Our practice utilizes e-prescribing. Prescriptions are sent electronically to the pharmacy of your choice for safety and convenience.

GUARANTOR (PARTY RESPONSIBLE FOR PAYMENT) If Guarantor is patient, check here ❑ and skip to next section.

Last Name: _____ **First:**_____ **SS#:**_____

Address: _____**City:**_____ **State:** _____ **Zip:**_____

Home Phone:_____**Work Phone:**_____ **Sex:**_____ **Date of Birth:** _____/_____/_____

Relationship to Patient: ❑**Spouse** ❑**Parent** ❑**Legal Guardian**

EMERGENCY CONTACT : Name:_____ Phone: (_____) _____ -- _____ Relationship:_____

PREVIOUS HOSPITALIZATIONS *(place, reason, & dates)*

Location	Reason	Dates
_____	_____	_____
_____	_____	_____

Payment Required At The Time Of Service, Unless Prior Arrangements Have Been Made.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original.

Signature _____ Date _____

Relationship (please circle one): PATIENT SPOUSE PARENT GUARDIAN

Patient Name:_____ **SS #**_____ **ACCOUNT#**_____

REASON FOR TODAY'S VISIT:_____

SMOKING STATUS *(check one)* ❑ **Never been a smoker** ❑ **Former smoker** ❑ **Current sometimes smoker** ❑ **Current every day smoker**

These questions are included to comply with new Federal Health guidelines -- we are required to ask for this information.	**Ethnicity** *(check one)*	❑ Hispanic or Latino	❑ Not Hispanic or Latino	❑Declined or Unspecified
	Race *(check one)*	❑ American Indian/Alaskan Native	❑ Asian	❑ Native Hawaiian/Other Pacific Island
		❑ Black/African American	❑ White	❑Declined or Unspecified
	Preferred Language *(check one,*	❑ English	❑ Spanish	❑Declined or Unspecified

MEDICATIONS (please list all prescription & over-the-counter medication)
If you currently DO NOT TAKE ANY MEDICATIONS, check this box ❑

_____ How long?_____
_____ How long?_____
_____ How long?_____

MEDICATION ALLERGIES: (please specify medication & reaction):

medication	reaction
_____	_____
_____	_____
_____	_____

REVIEW OF SYSTEMS Please check ☑ Yes or ☑ No – Do you have any of the following:

❑No ❑Yes	Asthma/Breathing Problems	❑No ❑Yes	Hay Fever / Seasonal Allergies	❑No ❑Yes	History Of Tb Or Exposure
❑No ❑Yes	Persistent Cough/Lung Conditions	❑No ❑Yes	History Of Heart Attacks	❑No ❑Yes	High Blood Pressure
❑No ❑Yes	Night Sweats	❑No ❑Yes	Depression	❑No ❑Yes	Seizures
❑No ❑Yes	Hallucinations	❑No ❑Yes	Headaches / Migraines	❑No ❑Yes	Vision Changes
❑No ❑Yes	Blind Spots	❑No ❑Yes	Nose Bleeds	❑No ❑Yes	Ringing In Ears
❑No ❑Yes	Persistent Sore Throat Or Toothaches	❑No ❑Yes	History Of Hepatitis	❑No ❑Yes	Arthritis
❑No ❑Yes	Extended Muscle Pain Or Weakness	❑No ❑Yes	Painful Urination	❑No ❑Yes	Diabetes
❑No ❑Yes	Thyroid	❑No ❑Yes	Sensitivity To Cold	❑No ❑Yes	History Of Eczema
❑No ❑Yes	History Of Psoriasis	❑No ❑Yes	History Of Blood Transfusions	❑No ❑Yes	Anemia
❑No ❑Yes	History Of IV Drug Abuse	❑No ❑Yes	Excessive Sweating	❑No ❑Yes	Heat Or Cold Intolerance
❑No ❑Yes	Blood In Stool	❑No ❑Yes	Abdominal Pain	❑No ❑Yes	Sudden Weight Loss Or Gain

❑No ❑Yes Cancer, if yes, what type?_____

❑No ❑Yes Any family history of skin cancer or other cancer? If yes, please describe: _____

❑No ❑Yes Have you ever been tested for HIV? If yes, what were your results? ❑Positive ❑Negative

FOR VEIN PATIENTS ONLY:
New Patients Do NOT initial this Box below

Family history of phlebitis?	❑No	❑Yes
History of blood clots/ clotting problems?	❑No	❑Yes
Family history of blood clots/ clotting problems?	❑No	❑Yes
History of pulmonary embolism?	❑No	❑Yes
History of phlebitis?	❑No	❑Yes
Family history of varicose veins?	❑No	❑Yes

FOR FEMALE PATIENTS:

Do you have abnormal periods?	❑No	❑Yes
Do you have excessive body hair?	❑No	❑Yes
Could you be pregnant?	❑No	❑ Yes
Are you currently breast feeding?	❑No	❑ Yes

Yearly Review With No Changes (initial below)

Initial_____ Date_____

Initial_____ Date_____

CURRENT MEDICAL CONDITIONS ***(check ☑ all applicable)***

Reactions or allergies to local anesthetics? (such as those used by the dentist)	❑ No	❑ Yes
Bleeding disorders, easy bruising or bleeding longer than most people when cut?	❑ No	❑ Yes
Have you ever fainted?	❑ No	❑ Yes
Do cuts on your skin heal with raised scars?	❑ No	❑ Yes
Are you allergic or have you had a "bad reaction" to any substances applied to your skin?	❑ No	❑ Yes
Allergies to Latex? (gloves)	❑ No	❑ Yes
Have you had previous cosmetic surgery?	❑ No	❑ Yes

If yes, please list _____

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OUR PRACTICE INFORMATION AND FINANCIAL POLICY

Welcome to the Skin & Vein Center. Our entire staff is dedicated to providing our patients with the highest quality of care and service. It is in this spirit that we are providing you with this important information. All patients must complete our patient information forms and provide a valid state issued ID before seeing the provider. If a provider in any of our offices has not seen you within the past 3 years or if you have been seen for cosmetic procedures only, you are considered a new dermatology patient and will be billed accordingly. **Full payment is expected at the time of service unless other prior arrangements have been made. We accept cash, checks, Mastercard/Visa, Discover, American Express and Care Credit.** With so many health insurance companies and contracts available today, it is very difficult for our staff to know exactly what your individual contract covers. Therefore, to avoid any financial "surprises" relating to the ***specialized services*** you receive at the Skin & Vein Center, please review your insurance policy for specific terms, conditions and coverage limitations.

Insurance:
We will **only** accept assignment of benefits with insurance plans in which we participate. Complete health insurance information is required to process insurance claims on your behalf. All patients are required to provide all current policy information. Insurance carriers have a filing time limit. If we do not have your correct insurance information before the filing time limit you will be responsible for all charges. Any remaining balances (such as co-pays, deductibles and non-covered services) are your responsibility. **Please note that all procedures done in a Dermatology office are considered surgery. Your policy may have a separate deductible for surgery. It is ultimately your responsibility to know what is covered through your policy.** If we do not participate in your plan, you will be responsible for any ANON-COVERED@ services under your policy and/or charges that may exceed your policies customary fee schedule. As a patient you have the right to refuse treatment.

Participating Physician: Do our physicians participate with your plan? You need to verify that the individual physician you are seeing is in your plan. Do not assume that all physicians in the same practice participate with your health plan. If you go to a physician outside of your plan's network, you may incur higher deductibles and/or co-pays. Please refer to your health plan's "provider directory," check their website or call them directly.

HMO'S: All HMO policies require authorization (written or verbal) from your primary care physician. Please call 1-2 days prior to your appointment to make sure we have received your referral and/or authorization. Please check your HMO guidelines regarding follow-up appointments. **Referrals and authorizations are your responsibility.** If you choose to be seen without a proper authorization/referral, payment will be your responsibility. Non-participating insurances that do not remit payment in a timely manner will be transferred to you to seek payment from your plan.

Minor Patients:

The parent/guardian accompanying the minor is responsible for payment. After their first visit with a parent /guardian, an unaccompanied minor must have a written consent authorizing other treatments. A parent/guardian must accompany minors for all biopsy/ surgical procedures.

Signature required on other side

Return Policy: Unopened products may be returned within 30 days of purchase. No returns are accepted on makeup.

Return Checks & Collections Services

Returned checks will be assessed a fee of $25.00. Balances over 60 days without pre-approved payment arrangements will be turned over to a third party collection agency. When turned over to an outside agency for collection, collection costs of 50 % (Fifty Percent) will be applied to your account**.**

Cosmetic Packages:
Cosmetic packages will be honored for 1 year and/or if broken by the patient for any reason will be charged at a single procedure price plus any products that were included. No show fees for cosmetics packages range from $50-$100 (depending on procedure).

Cosmetic Consultations / Visits: Cosmetic consults by themselves are always free of charge. But, at the time of your cosmetic consult / visit, if you are seen for a dermatology problem—your insurance will be billed for those services. Please check your insurance plan to see if these additional services are covered.

Acne Treatment: Many insurance companies will not cover the treatment of acne. ***We commonly treat acne with procedure code 10040 (acne surgery). The diagnosis code for acne is 706.1. Please check your insurance policy. Common Insurances that do not cover acne are: Priority Health Plan, Midwest Security, Humana and Humana through Cofinity, and Assurant Health. If you have these plans, any treatments are considered not covered.*** Office visits may or may not be covered. You would need to check with your insurance carrier.

Varicose Veins: Some insurance companies do not cover the treatment of veins (Sclerotherapy) because they view them as a cosmetic procedure. Other plans may cover these treatments but require a "pre authorization" prior to treatment. In order to receive a "pre authorization" from your health plan, we are required to send them medical information after your vein consultation. Without this approval your vein treatments will not be covered. Also, a Venous Doppler (Ultrasound) and test dose may be required before treatment begins, which is a test many plans do not cover.

By my signature below, I acknowledge my understanding of all points in your financial policy. I authorize the release of medical information for the purpose of processing insurance claims on my behalf. I authorize payment of medical benefits directly to the provider for services provided to me. A copy of this authorization shall be considered as valid as an original signature.

_____ _____ _____

Signature of Patient/Guardian Relationship to Patient Date

_____

Print Name of Patient/Guardian

****

PRIVACY NOTICE ACKNOWLEDGMENT

I have been offered or received a copy of the Skin & Vein Michigan=s Notice of Privacy Practices.

_____

Signature of Patient/Guardian

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Consent for dermatologic treatment

The providers of Skin & Vein Centers have an obligation to discuss with you, your condition and the recommended surgical procedure to be performed. This discussion is intended to ensure you are completely informed and had the opportunity to make a reasonable decision whether or not to consent to the procedure.

There are many diagnoses in Dermatology to be listed, below are a few that are seen in our office:
• **Acne Vulgaris • Acrochordons • Angioma/ Telangiectasia(s) • Condyloma Acuminatum • Flat Warts • Contact Dermatitis**
•Seborrheic Keratosis • Molluscum Contagiosum • Verruca Vulgaris • Plantar Warts • Actinic Keratosis • Psoriasis • Eczema

There are several methods used to treat the different diagnoses in addition to shave and or excision removal.

1. Cryosurgery- is the treatment of lesions with the application of a cold substance. The cold substance (liquid nitrogen) is used to destroy the lesion.
2. Chemical- is the treatment of lesions with the application of a chemical. The chemical is used to destroy the lesion.
3. Injection / Dermajet- a low dose steroid medication is used by injecting into the affected areas for treatment.
4. Puva – is light therapy to treat your condition

The physician and/or associates have explained to my satisfaction the following:

1. There is no single treatment that can guarantee successful treatments.
2. Treatments may require 1 or more methods or combinations of several treatment options.
3. Multiple treatments may be required.
4. The treated area(s) may develop new lesions.
5. There may be a recurrence to the treated areas.
6. The treated area(s) may leave a scar(s).
7. Blisters may occur with treatments with the exception of Acne.

Call the office if you see signs of infection - pus, redness or increasing pain or have any further questions.

If you are coming in for the removal of skin tags, this is not a covered procedure by insurance companies with the exception of Blue Cross Messa. You are responsible for the cost of having these lesions removed. The cost to you will be:

$50.00 for lesions 1 -10
$100.00 for lesions 11-20
$150.00 for lesions 21-30 (tags over 30 will be charged at $5.00 each)

The treatment of angiomas / telangiectasia(s) are same price as skin tags (multiple treatments can be needed).

LESION REMOVAL: Any lesion removed that is considered cosmetic will be given a quote price by the physician and is due at time of service. *Any lesion removed is sent to an independent laboratory*. There are two parts in billing for a lesion removed. The outside lab prepares the lesion. The second part is for a diagnosis, which may be billed by the outside laboratory or from our office. You must contact the lab in regards to their billing. Outside lab fee - $109.00 and up Our office fee - $75.00/ diagnosis read only

Some insurance carriers may consider treatment for your diagnosis as cosmetic; you may contact your carrier to verify benefits before consenting to treatment. Any balance, after insurance payment is made, such as co-payment, un-met deductibles or non-covered services is patient responsibility.

My signature below signifies my willingness to proceed with treatment for a period of up to one year if necessary, fully realizing the issues identified above. If after one year my treatment needs to be continued, I understand I will need to resign a new consent.

_____ _____
Patient signature Date

_____
Parent / Guardian Signature (Minor Patients)