



PATIENT REGISTRATION & MEDICAL HISTORY

PATIENT INFORMATION

Name _____ SSN _____ Date _____
Last First M
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 [] _____
Email _____ 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 [] Current Patient [] Internet [] E-Newsletter [] 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: _____ SSN _____
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, and dates)

Location	Reason	Dates

PAYMENT REQUIRED AT 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

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305 N. Leroy St.
Fenton, MI 48430
810-629-9200

STERLING HEIGHTS
44056 Mound Rd. Ste. 101
Sterling Heights, MI 48314
586-314-1400

LIVONIA
10984 Middlebelt Rd.
Livonia, MI 48150
734-762-0798

SKIN & VEIN CENTER

DERMATOLOGY · COSMETIC SURGERY · DERMSPA

Patient Name: _____ SSN _____ ACCT # _____

REASONS FOR TODAY'S VISIT: _____

Smoking Status (check one) Never been a smoker Former smoker Current sometimes smoker Current everyday smoker

These questions are included to comply with new Federal Health guidelines - we are required to ask for this information.	Ethnicity (check one)	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino	<input type="checkbox"/> Declined or Unspecified
	Race (check one)	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> Native Hawaiian/Other Pacific Island
	Preferred Language (check one)	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Declined or Unspecified

MEDICATIONS (please list all prescriptions & over-the-counter medication) **MEDICATION ALLERGIES** (please specify medication & reactions)

Medication	Reaction
If you currently do not take any medications, check this box <input type="checkbox"/>	
_____ How long? _____	_____
_____ How long? _____	_____
_____ How long? _____	_____

REVIEW OF SYSTEMS Please check Yes No - Do you have any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> No <input type="checkbox"/> Yes Asthma/Breathing Problems | <input type="checkbox"/> No <input type="checkbox"/> Yes Hay Fever/Seasonal Allergies | <input type="checkbox"/> No <input type="checkbox"/> Yes History of TB or Exposure |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Persistent Cough/Lung Conditions | <input type="checkbox"/> No <input type="checkbox"/> Yes History of Heart Attacks | <input type="checkbox"/> No <input type="checkbox"/> Yes High Blood Pressure |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Night Sweats | <input type="checkbox"/> No <input type="checkbox"/> Yes Depression | <input type="checkbox"/> No <input type="checkbox"/> Yes Seizures |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Hallucinations | <input type="checkbox"/> No <input type="checkbox"/> Yes Headaches/Migraines | <input type="checkbox"/> No <input type="checkbox"/> Yes Vision Changes |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Blind Spots | <input type="checkbox"/> No <input type="checkbox"/> Yes Nose Bleeds | <input type="checkbox"/> No <input type="checkbox"/> Yes Ringing in Ears |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Persistent Sore Throat or Toothaches | <input type="checkbox"/> No <input type="checkbox"/> Yes History of Hepatitis | <input type="checkbox"/> No <input type="checkbox"/> Yes Arthritis |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Extended Muscle Pain or Weakness | <input type="checkbox"/> No <input type="checkbox"/> Yes Painful Urination | <input type="checkbox"/> No <input type="checkbox"/> Yes Diabetes |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Thyroid | <input type="checkbox"/> No <input type="checkbox"/> Yes Sensitivity to Cold | <input type="checkbox"/> No <input type="checkbox"/> Yes History of Eczema |
| <input type="checkbox"/> No <input type="checkbox"/> Yes History of Psoriasis | <input type="checkbox"/> No <input type="checkbox"/> Yes History of Blood Transfusions | <input type="checkbox"/> No <input type="checkbox"/> Yes Anemia |
| <input type="checkbox"/> No <input type="checkbox"/> Yes History of IV Drug Abuse | <input type="checkbox"/> No <input type="checkbox"/> Yes Excessive Sweating | <input type="checkbox"/> No <input type="checkbox"/> Yes Heat or Cold Intolerance |
| <input type="checkbox"/> No <input type="checkbox"/> Yes Blood in Stool | <input type="checkbox"/> No <input type="checkbox"/> Yes Abdominal Pain | <input type="checkbox"/> No <input type="checkbox"/> 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: **FOR FEMALE PATIENTS:**

New Patients do NOT initial this Box below

Family history of phlebitis? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have abnormal periods? <input type="checkbox"/> No <input type="checkbox"/> Yes	Yearly Review With No Changes
History of blood clots/clotting problems? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have excessive body hair? <input type="checkbox"/> No <input type="checkbox"/> Yes	(initial below)
Family history of blood clots/clotting problems? <input type="checkbox"/> No <input type="checkbox"/> Yes	Could you be pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	Initial _____ Date _____
History of pulmonary embolism? <input type="checkbox"/> No <input type="checkbox"/> Yes	Are you currently breastfeeding? <input type="checkbox"/> No <input type="checkbox"/> Yes	Initial _____ Date _____
History of phlebitis? <input type="checkbox"/> No <input type="checkbox"/> Yes	Family history of varicose veins? <input type="checkbox"/> No <input type="checkbox"/> Yes	

CURRENT MEDICAL CONDITIONS (check all applicable)

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

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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.

Return Policy: Unopened products may be returned within 14 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 L700. Please check your insurance policy. Common Insurances that do**

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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 ACKNOWLEDGEMENT

I have been offered or received a copy of the Skin & Vein Centers 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) _____

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