Patient Name: _____

Account Number: _____

Referred by: _____

Esthetician Services Information and Consent Form

General and Medical Information

What skin care products do you currently use? _____

Have you ever had chemical peels, lasers, microdermabrasions, or any skin resurfacing treatments? _____ If yes, when was your last treatment? _____

Do you use Retin-A or any other prescription strength skin products?

_____

Do you use any acne medication? What kind? _____

Do you experience an oily shine during the day? _____

Do you experience any flakiness or tightness during the day? _____

Do you wear SPF? _____ Do you experience breakouts? _____

Are you taking oral contraceptives? _____ Are you pregnant? _____

Do you wear contact lenses? _____ Do you smoke? _____

Do you sunbathe or use tanning beds? _____ Do you have a tendency to redness? _____

Have you ever had a reaction to skin care products? If so what? _____

Are you under a dermatologist's care for a skin condition? If so, please explain:

_____

List any allergies: _____

If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort I further understand that facials should not be constructed as a substitute for medical examination, diagnosis, or treatment I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical illness, and that nothing said in the course of the session given should be construed as such Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatments are contraindicated

Patient Signature: _____ Date _____

Staff Signature: _____ Date _____

Cassis Dermatology & Aesthetics Center

PATIENT INFORMATION

PLEASE PRINT

GENDER (please circle) Male Female

PATIENT _____
FIRST MIDDLE LAST

ADDRESS _____
STREET PO BOXES MUST INCLUDE STREET ADDRESS CITY STATE ZIP COUNTY

BIRTHDATE___/___/_____ HOME PHONE _____/_____-_____

MARITAL STATUS S M D W O WORK PHONE _____/_____-_____ EXT _____

EMAIL ADDRESS_____ CELL PHONE _____/_____-_____

BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

☐ CHECK BOX TO RECEIVE EMAILS ABOUT COSMETIC PROMOTIONS AND SPECIALS

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD

GUARANTOR _____
FIRST MIDDLE LAST

ADDRESS _____
STREET CITY STATE ZIP COUNTY

EMPLOYER / SCHOOL _____
NAME & ADDRESS

BIRTHDATE _____/_____/_____

BEST NUMBER BTWN 9AM & 4PM (Please circle One) Home Work Cell _____/_____-_____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD

GUARANTOR _____
FIRST MIDDLE LAST

ADDRESS _____
STREET CITY STATE ZIP COUNTY

EMPLOYER / SCHOOL _____
NAME & ADDRESS

BIRTHDATE _____/_____/_____

BEST NUMBER BTWN 9AM & 4PM (Please circle One) Home Work Cell _____/_____-_____

RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT INFORMATION

1) NAME _____ RELATIONSHIP TO PATIENT _____

HOME PHONE _____/_____-_____ CELL PHONE _____/_____-_____

WORK PHONE _____/_____-_____ ext_____ BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

2) NAME _____ RELATIONSHIP TO PATIENT _____

HOME PHONE _____/_____-_____ CELL PHONE _____/_____-_____

WORK PHONE _____/_____-_____ ext_____ BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

Dermatology Medical History

Referred by: _____

Patient: _____ Age: _____ Today's Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1 _____ 2 _____

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds , vitamins, and herbals):
1 _____ 3 _____ 5 _____
2 _____ 4 _____ 6 _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO If yes, TYPE: _____
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____
Do you have problems with healing ❑ YES ❑ NO
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Topical Neosporin ❑ Other _____

Social History:
Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____
Do you smoke? ❑ YES ❑ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS) ? ❑ YES ❑ NO HEPATITIS? If YES, TYPE: A B C

Please answer the following questions:
(Women) Are you pregnant? ❑ YES ❑ NO Due Date: ___/___/___
What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient ❑ Medical Assistant _____ Initials

_____ Signed by Patient ___/___/___ Date

_____ Reviewed by ___/___/___ Date

Cassis Dermatology & Aesthetics Center

INSURANCE AND BILLING AUTHORIZATION

I understand I am personally responsible to Cassis Dermatology & Aesthetics Center (The Practice) for any charges incurred for services performed regardless of insurance coverage. I accept full FINANCIAL RESPONSIBILITY for the patient's account in accordance with the regular rates and terms of The Practice's policy.

I understand most health insurance carriers require The Practice to file a claim for my services, but that I am responsible for any and all amounts not covered and not paid by my insurance carrier. These amounts may include co-payments, deductibles, and fees not covered by my health insurance. IF MY INSURANCE CARRIER REQUIRES A REFERRAL FOR MY OFFICE VISIT, I UNDERSTAND IT IS MY RESPONSIBILITY TO OBTAIN THIS AND PRESENT THIS REFERRAL AT THE TIME OF MY VISIT (IF NOT BEFORE). Failure to obtain a referral, if required, does not release me from my responsibility to The Practice. SERVICES PROVIDED WITHOUT A REFERRAL, IF A REFERAL IS REQUIRED, REMAIN MY RESPONSIBILITY.

I understand that if I am not covered under a current insurance policy or if I do not present a current insurance card at the time of service, that I will be responsible for payment in full at the time services are rendered.

Most aesthetic services are not covered by health insurance. Biopsy and removal of skin lesions may not be covered by my health insurance. I am responsible for payment of any aesthetic services or treatments or any medical conditions not covered by my insurance.

I hereby authorize The Practice to submit a claim to my Insurance Carrier or it's intermediaries related to services rendered by any physician or medical provider employed by Cassis Dermatology & Aesthetics Center, and direct my insurance carrier or it's intermediaries to issue payment directly to The Practice and/or provider who accepts assignment.

Signature _____ Date _____

NO SHOW FOR APPOINTMENTS AND COLLECTION FEES

I understand when The Practice provides an appointment time; I remain responsible for payment for services. If I fail to notify The Practice with 24-hour notice, I remain responsible for payment for my appointment. Failure to notify The Practice may result in a $25 no show fee. I understand my health insurance will not cover this fee, and I will remain personally responsible for payment of this fee. Repeated failure to show for appointments may result in my dismissal from The Practice.

If Cassis Dermatology & Aesthetics Center refers my account to a collection agency, I agree to a pay all fees, collection fees and legal fees, associated with my delinquent account. I understand I will be responsible for any collection fees, including any legal expenses incurred in settling my delinquent account. I understand a delinquent account may be reason for termination from The Practice.

Signature _____ Date _____

CONSENT FOR CARE AND TREATMENT OF DEPENDENT

PERMISSION FOR TREATMENT is hereby grant to any physician or medical provider employed by The Practice to render such medical and surgical treatment as deemed necessary for

Dependent's Name _____

Signature of Parent or Guardian _____ Relationship to Patient _____

NOTICE OF PRIVACY PRACTICES

I acknowledge Cassis Dermatology & Aesthetics Center (the Practice) has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature _____ Date _____

Printed Name of Patient or Personal Representative (If different than patient only) _____ Relationship to Patient _____

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION

I hereby consent to Cassis Dermatology & Aesthetics Center using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me, or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals

Signature _____ Date _____

Printed Name (if different than patient only) _____ Relationship to Patient _____

SPECIFIC INFORMATION RELEASE (if applicable)

I specifically authorize release of the following information for the purposes of treatment, payment, and health care operations:
(Initial any you agree to release)

_____ Chemical Dependency/Substance Abuse

_____ Sexually Transmitted Diseases

Signature _____ Date _____

Printed Name (if different than patient only) _____ Relationship to Patient _____

Cassis
Dermatology & Aesthetics Center

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the quality treatment of each and every patient. Please understand that payment for your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

All patients must complete our Patient Registration process prior to seeing the physician.

WE ACCEPT CASH, CHECKS, VISA & MASTERCARD.
In the event of a returned check, for any the following reasons: non-sufficient funds, stop payment or closed account, a fee of $30.00 will be charged to your account

INSURANCE CARD

We will not bill your insurance company unless you provide a current insurance card

PARTICIPATING PROVIDER (CONTRACTED)

We accept assignment of insurance benefits on many insurance plans. During the Patient Registration process you will be told whether or not we accept assignment of your insurance benefits. We will file all charges to your insurance company. Because we are a participating provider with your insurance carrier, you be responsible to pay any **co-pay** amounts **each visit**. You will also be responsible for any deductible/coinsurance amounts, as stated in your policy, and you will receive a statement in the mail, from our office, for these amounts. If you participate in a High Deductible Insurance Plan, you will be asked to pay at the time of service. We will file the claim on your behalf with your carrier. Any charges considered cosmetic, non-covered or not medically necessary will be your responsibility and will be **due in full at the time of service**.

NON-PARTICIPATING PROVIDER (NON-CONTRACTED)

Because we are not contracted with your insurance carrier, you will be responsible to pay your total charges. We will file all charges to your insurance company. You will be responsible for any charges not covered by your insurance carrier, as stated in your policy. We will allow 45 days to receive payment from the insurance carrier; if not received, the entire balance will be billed to you. You will receive a statement in the mail from our office for these amounts. Any charges considered cosmetic, non-covered or not medically necessary will be your responsibility and will be **due in full at the time of service**. We will ***not*** follow-up with your insurance carrier on any unpaid claim. It is your responsibility to work directly with your insurance carrier on any disputed or unpaid claims.

RATES

Our practice is committed to providing the best treatment for our patients at a rate considered usual and customary for our area.

MINOR PATIENTS

Minor patients must be accompanied by a parent or legal guardian each visit. The parent/legal guardian accompanying the minor to the first visit will be considered guarantor on the account; therefore, accepting full financial responsibility for all services rendered on the minor's behalf and charged to their account

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X _____
Patient Name (Please Print)

X _____ Date _____
Signature of Patient or Responsible Party

X _____ Date _____
Signature of Co-Responsible Party