Carroll Dermatology Surgery and Laser Institute, LLC

THERE ARE 4 FORMS FRONT AND BACK

PATIENT NAME (LAST, FIRST, MI):_____

DATE OF BIRTH: _____
SEX: MALE FEMALE

HOME PHONE #_(___)_____CELL PHONE #:_(___)_____

PRIMARY HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP_____

ALTERNATIVE ADDRESS (OUT OF STATE)

_____

CITY:_____ STATE:_____ ZIP:_____ HOME PHONE: (___)_____

EMAIL ADDRESS:_____

Pharmacy Name:_____

PHONE Number: _____

Cross Streets:_____

OCCUPATION:_____

ADDRESS:_____ PHONE: (___)_____

Name of Parent or Guardian if applicable:
Name:_____ **DOB:**_____
PHONE (___)_____

NOTIFY IN CASE OF EMERGENCY
NAME:_____
RELATIONSHIP:_____ PHONE: (___)_____

PRIMARY CARE PHYSICIAN_____
PHONE:_____
I hereby aknowledge that all of the above information is accurate and complete to the best of my ability.

PATIENT NAME:_____ DATE:_____
PATIENT SIGNATURE:_____
AUTHORIZED REPRESENTATIVE:_____

MEDICAL HISTORY

PATIENT:_____ DATE OF BIRTH:_____/_____/_____ AGE:____

(Last) (first) (M.I.)

PERSONAL HISTORY: (please check all appropriate boxes)

__ANXIETY DISORDER
__ARTHRITIS
__ASTHMA
__ATRIAL FIBRILLATION
__CHRONIC LUNG DISEASE
__CORONARY ARTERIOSCLEROSIS
__DEPRESSION DISORDER
__DIABETES
__ELEVATED BLOOD PRESSURE
__EPILEPSY
__GASTRO REFLUX DISEASE
__HYPOTHYROID
__LEUKEMIA
__HEARING LOSS
__HYPERCHOLESTEROLEMIA
__HYPERTHYROID
__MALIGNANT LYMPHOMA
__MALIGNANT TUMOR OF BREAST
__MALIGNANT TUMOR OF COLON
__MALIGNANT TUMOR OF LUNG
__MALIGNANT TUMOR OF PROSTATE
__MENINGITIS
__MIGRAINE HEADACHES
__AIDS/HIV
__SYPHILIS
__VENEREAL DISEASE
__SHINGLES
__LIVER DISEASE
__HEPATITIS

OTHER:_____

New Medications:(please list all medicines including Aspirin, birth control pills, vitamins/supplements, diet pills, etc.)

_____

_____

SKIN CONDITIONS:

__ACTINIC KERATOSIS
__BASAL CELL CARCINOMA
__CONTACT DERMATITIS
__ECZEMA
__HAY FEVER
__PSORIASIS
__SQUAMOUS CELL CARCINOMA
__SUNBURN
__KELOIDS
__SKIN INFECTIONS
__HERPES/COLD SORES
__HIVES

<u>THERE ARE 4 FORMS FRONT AND BACK</u>

Do you sunburn easily? _____ **Do you wear sunscreen?**_____

Family History of Melanoma?
Who? _____

ALLERGIES TO:

Epinephrine _____
Latex _____
Lidocaine _____
Tape/bandage _____
Anesthetic (local) ___

How did you hear about our

practice_____

Referred by:_____

Patient Name:_____

Patient Signature:_____

Date:_____Parent or authorized

representative:_____

AESTHETICS INTAKE FORM

BODY

1. Are there areas of your body you would like to reduce fat?

Comments: _____

2. Are there areas of your body you would like to build muscle?

Comments: _____

3. Are you concerned with your core strength? Or have low back pain?

Comments: _____

4. Are you currently on a diet or exercise program?

Comments: _____

5. Have you done any fat reduction treatments or procedures?

Comments: _____

Please indicate any body areas that you are interested in discussing further:

Arms Love Handles Abdomen Thighs Glutes Other:_____

FACE

1. Are you concerned with the aging of your face?

Comments: _____

2. Would you like to see less wrinkles and fine lines?

Comments: _____

3. Would you like more lift to your facial structure?

Comments: _____

4. Are you currently getting neurotoxin or filler injections?

Comments: _____

5. Have you done any anti-aging facial treatments or procedures?

Comments: _____

Carroll Dermatology Surgery and Laser Institute, LLC

NEW PATIENT NOTICE OF PRIVACY
AND DISCLOUSRE OF HEALTH INFORMATION

I understand that as part of my healthcare, Carroll Dermatology Surgery and Laser Institute, LLC, and its physician(s) originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that as part of this organizations treatment, payments, and healthcare operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

The complete Privacy Notice of Carroll Dermatology Surgery and Laser Institute, LLC and its physician(s) is available in the office for my perusal. I may also request my own copay if I desire.

I fully understand and accept the terms of this consent.

Patient Name (print):_____
Date:_____
Patient Signature:_____

Parent or Authorized Respresentative (if applicable):

_____
If patient is a minor (under 18) check relationship __ Mother __ Father __ Other_____

Please complete the following information:

Name of person(s) with whom we may discuss your medical information (i.e. wife/husband , child, etc.)
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

May we leave a message on your answering machine for the following:
Laboratory/ Pathology Results: Y_____ N_____

PHOTOGRAPH AND VIDEO RELEASE FORM

I hereby authorize, disclose and provide to Carroll Dermatology Surgery and Laser Institute ("Carroll Dermatology") all the rights of my image, likeness and sound of my voice as recorded on audio or video tape ("Materials") in conjunction but not limited to treatments and procedures provided by Carroll Dermatology. Subject to the Scope of Release set forth below, I release to Carroll Dermatology the right to these Materials, I assign to Carroll Dermatology any copyright rights I may have to the Materials, and I consent to the publication and use of such Materials by Carroll Dermatology as set forth below.

I authorize the use of these Materials by Carroll Dermatology, its agents and assigns (collectively "Licensees"), the right to use my name, likeness and the Materials, in whole or in part, whether in original or modified form, whether alone or in conjunction with other photographs, text, art work and other materials for Licensee's internal and public relations and commercial purposes, and for advertising and marketing purposes relating to Licensees' products and services, in perpetuity throughout the world. Such use includes, but is not limited to: advertising, publicity or promotion in any media; Licensees' internal use for research and development and quality control; communications to physicians; publication in medical journals and/or textbooks for physician education; and for use in physician-to-physician lectures.

I hereby waive all rights to inspect and approve the finished product, its use or such copy as may be used in connection therewith.

I further agree that I will not hold Licensees responsible for any liability resulting from the use of my likeness or Materials in accordance with the terms hereof, including claims for invasion of the right of privacy or for what might be deemed to be misrepresentation of my character or person due to distortion, optical illusion or faulty reproduction which may occur in the finished product.

I understand that once these Materials have been disclosed to Carroll Dermatology, they will no longer be protected by privacy laws. However, Carroll Dermatology will not use the Materials except as permitted on this authorization form.

I hereby release Carroll Dermatology, its successors, affiliates and assigns, from any claim, demand, cause of action, or proceeding of whatever nature arising out of any use, publication and/or distribution of Materials in accordance with the terms of this Release.

I represent that I am over the age of 21 and that I give this Release freely and voluntarily.

_____

Print Name Signature Date

Provider's Agreement and Consent:

I agree to disclose to Carroll Dermatology the Materials referenced in the above Release and I consent to the uses set forth therein.

_____

Provider's Name Signature Date

Carroll Dermatology Surgery and Laser Institute, LLC

Diseases & Surgery of the Skin, Hair, and Nails

Statement of Financial Responsibility & Release of Information

1. HMO/ PPO/ Commerical Insurance:

I understand that Carroll Dermatology Surgery and Laser Institute, and its physician(s) will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Marianne Carroll DO PA, and its physician(s) of medical benefits, for the services provided. **I understand that I am financially responsible for my health insurance deductibles, coinsurance, and non-covered services. I also understand that I am responsible for all necessary referrals if indicated by my insurance plan.**

Name of patient_____ Date_____
Patient Signature_____ Parent/Guardian_____

2. MEDICARE AND MEDICAID ONLY:

Lifetime Authorization:

I certify that the information given by me in applying for payment under Title XVIII and/or XIX of Social Security Act is correct, and request that said payment of authorized benefits are made on my behalf. I understand that I am financially responsible for my deductible, coinsurance, and non-covered services. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediary carriers, any information needed for their Medicare/Medicaid claim. I hereby irrevocably assign payment to Carroll Dermatology Surgery and Laser Institute, and its physician(s) accepting assignment of all medical benefits applicable and otherwise payable to me. **I also understand that Medicare will cover 80% of covered charges and I will be responsible for the other 20% unless covered by a supplemental insurance.**

Signature as it appears on card_____ **Date**_____

If you have a **supplemental** 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 my medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on card_____ **Date**_____

3. PAYMENT AND RELEASE OF INFORMATION

I hereby assume responsibility to pay all costs of services provided by to Carroll Dermatology Surgery and Laser Institute, and its physician(s) to the patient. My signature below signified my understanding and willingness to comply with this policy.

*All payments are due at the time services are rendered unless prior arrangements have been made to Carroll Dermatology Surgery and Laser Institute will accept cash, check, Visa, MasterCard, American Axpress and Discover for your convenience. I agree to be responsible for any cost incurred in the collection or litigation of any unpaid balance. If the amount owed is not fully satisfied by the date due, the a fee of 35% of the understanding balance (as calculated on the due date) will be added to the outstanding balance and sent to a collection agency.

Any returned check shall be subject to a $25 fee.

Name of patient_____ Date_____
Patient Signature_____
Parent/ Guardian_____

Carroll Dermatology Surgery and Laser Institute, LLC
Diseases & Surgery of the Skin, Hair, and Nails

NO-SHOW Policy

(New Policy as of 7/01/24)

I understand that if I make an appointment with Carroll Dermatology it is my responsibility to show up to my scheduled appointment, if I can't make it I will call the office and advise If I need to either re schedule or cancel the appointment at minimum 2 hours before my scheduled appointment. If I do NOT inform the office and my appointment is made a NO-SHOW then I am aware I will be charged a $50 NO-SHOW fee which is done after the 15 minute window given to patients. We try and accommodate all our patients and try to give our patients the time, respect and attention they expect from us. We appreciate it if all of our patients respect not only our providers and staffs time but also others patients' time. If the account has multiple NO-SHOWs we do have the right to not book any future appointments and will discharge the patient from the practice if necessary. Thank you.

Patient Name:_____

Patient Signature:_____

Date:_____