# Skin & Laser Surgery Center, P.C.

## Dermatology, Laser, Cosmetic & Mohs Skin Cancer Surgery

1359 Beverly Rd 2nd Floor Mclean, VA 22101 •2200 Opitz Blvd, Suite 100, Woodbridge, VA 22191

### PATIENT INFORMATION

Todays Date: (month) _____/(day)_____/(year)_____ Preferred Language: ☐English ☐Spanish ☐Other_____

**Name:** _____
(Last) First) (MI)

*Do you have a preferred name or nick name?:* _____

**Sex:** ☐Male ☐Female **Date of Birth:** _____/_____/_____ Age: _____ **Social Security #:** _____-_____-_____

Address: _____
(Street Address) (Town/City) (State) (Zip)

Home Telephone No: (_____)_____Cell Phone No: (_____)_____
What is the best way for us to reach you? ☐Home ☐Cell ☐Other Phone (_____)_____
May we leave a message about your test results? **YES/NO** with ☐Spouse, ☐Household member, ☐Other_____

**Marital Status:** ☐Single ☐Married ☐Other_____ ***Email:** _____@_____
*Can we send you any information via your email? **YES/NO**

**Race:** _____ **Ethnicity:** _____

How would you like to receive appointment reminders? ☐E-mail ☐Call
Name of parents or guardian (**if patient is child or under 18 years old**):
Father: _____ **Social Security #:** _____-_____-_____
Mother: _____ **Social Security #:** _____-_____-_____

**Emergency Contact Name:** _____Relation to patient____ _____
Phone: (_____)_____

Is patient employed? **YES/NO** (Please Circle) If employed, please fill out the following:

Name of Employer: _____

Phone: (_____)_____Address: _____

### ADDITIONAL INFORMATION

Name of PRIMARY CARE PHYSICIAN: _____

Address: _____
(Street Address) (Town/City) (Zip)

Phone: (_____)_____ Fax: (_____)_____

Please list any other physicians who you see: _____

_____

Name of PHARMACY: _____ Phone: (_____)_____

Address: _____
(Street Address) (Town/City) (Zip)

How did you hear about us? Please Circle ALL that applies:

a. Insurance Company Website or Directory
b. Friend/ Relative/Colleague_____
c. Doctor's Name: _____
d. Yellow Pages (Verizon / Yellow Book/ Local-Community Book)
e. Google Search/Internet/Website name: _____
g. Other _____

### HIPAA PRIVACY AUTHORIZATION

I have the right to review the Notice of Privacy Practices prior to signing this consent.

☐**I authorize** Skin & Laser Surgery Center, PC to use and disclose my protected health information for its own purposes of treatment, payment, and health care operations. This authorization expires one year from date of signing **or** on _____.
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim
You may decline to sign this authorization. Declining to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits unless this authorization is being performed solely to create information to be sent to another entity. **Initials**_____ You have the right to receive a copy of this authorization.

_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

*PLEASE TURN OVER.*

Updated 02/12/2015 MY &ST

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### PRIMARY Insurance Information

**IF YOU HAVE MEDICARE DO YOU HAVE A MEDICARE REPLACEMENT PROGRAM ☐YES ☐NO**

**Name of Policy Holder**_____

**Date of Birth of Policy Holder:** _____/_____/_____ **Social Security # of Policy Holder:** _____-_____-_____

**Name of Primary Insurance:** _____ **ID NO:** _____

**Primary Insurance Co. Phone #:** (_____)_____ **Group #:** _____

**Policy Holder's Address:** _____
(Street/P.O. Box) (Town/City) (State) (Zip Code)

**Employer Insurance Plan?** ☐Yes ☐No

**Relationship of Patient and Policyholder:** ☐Self ☐ Husband ☐Wife ☐Child ☐Parent

### SECONDARY Insurance Information

**Name of Policy Holder**_____

**Date of Birth of Policy Holder:** _____/_____/_____ **Social Security # of Policy Holder:** _____-_____-_____

**Name of Primary Insurance:** _____ **ID NO:** _____

**Primary Insurance Co. Phone #:** (_____)_____ **Group #:** _____

**Policy Holder's Address:** _____
(Street/P.O. Box) (Town/City) (State) (Zip Code)

**Employer Insurance Plan?** ☐Yes ☐No

**Relationship of Patient and Policyholder:** ☐Self ☐ Husband ☐Wife ☐Child ☐Parent

### ASSIGNMENT & RELEASE

I hereby authorize Skin & Laser Surgery Center, PC to apply for benefits on my behalf for covered services rendered. I, further, authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). Either my insurance carrier or I may revoke this authorization at any time in writing. I certify that information I have reported with regard to my insurance coverage is correct. I authorize Dr. Bajoghli, Associates and staff to treat me. I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Skin & Laser Surgery Center, PC for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original.

***In the event my health plan determines a service to be non-covered, I will be responsible for the complete charge. Skin & Laser Surgery Center, PC will bill me directly and payment is due upon receipt of the statement. Skin & Laser Surgery Center, PC will also bill your health plan for all services we provide in the hospital. For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.**

I understand and agree that *I am financially responsible for charges not covered by my insurance* company.

### APPOINTMENT POLICY

**There will be a $50.00 charge for a NO SHOW office visit or an $85.00 charge for NO SHOW SURGERY appointment.** We strictly enforce this policy, so please take time to carefully select your appointment time. A broken appointment is a cancellation without a 24-hour notice, lateness that results in the inability to properly complete the treatment planned, or not being present for the scheduled appointment.

### PAYMENT POLICY

Self pay accounts, co-pay, deductibles and/or co-insurances are due at the time of service; there is no exception to this policy. If it becomes necessary to turn your account over to a collection agency/attorney, there will be a charge of 35% additional fee applied to your total balance to cover attorney's fees and other collection costs.

If your check bounces (due to insufficient funds or any other reason) you will be charged $50.00 ASF Fee.

### INSURANCE COVERAGE

It is not Skin & Laser Surgery Center's responsibility to confirm whether the patient has in-network or out of network benefits. Ultimately, it is the patient's responsibility to confirm what their coverage benefits are with their insurance company.

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

# Skin & Laser Surgery Center, P.C.

1359 Beverly Rd. Suite 200, McLean, Virginia 22101 2200 Opitz Blvd, Suite 100, Woodbridge, Virginia 22191

## COSMETIC INFORMATIONAL FORM

**Patient Name:** _____

**Would you like to receive information regarding any of the following services we offer?**
**If so, please indicate how you would like to receive correspondences, via email _____? or via mail _____?**

**Please Circle services you are interested in:**

1. **Botox** (Forehead wrinkles, Frown lines, Crows feet around the eye wrinkles or for treatment of excessive sweating)
2. **Blepharoplasty** (Upper eyelid excess correction)
3. **Collagen** for Lip or Laugh line Treatment
4. **Facial Peels / Chemical Peels** for acne/blemishes
5. **Laser Hair Removal**
6. **Laser Treatment** for Scars/Wrinkles
7. **Laser for Red Spots** (Leg Veins & Facial Redness Rosacea Scars, Stretch marks)
8. **Laser for Pigmented Lesion** (Brown Spots, Tattoos, Age Spots, "Liver Spots")
9. **Leg Veins Treatment** (Sclerotherapy or Laser treatment)
10. **Lip Enhancement**
11. **Microdermabrasion** (for acne or blemishes, smoother skin)
12. **Photo Rejuvenation** (Laser or Light resurfacing for wrinkles)
13. **Wrinkle Treatments with Restylane, Radiesse, Perlane** Injections for laugh lines and lip augmentation
14. **Sculptra Injections** for Enhancing Cheeks and Lips
15. **Photodynamic Therapy** for blemishes, acne scarring
16. Any other procedures you are interested in, yet not listed above? _____

_____

17. Any other comments or suggestions? _____

_____

18. **NONE**

Thank you for your time.

**Please visit www.bderm.com for more Information**

# PATIENT EMAIL/TEXT REQUEST AND INFORMED CONSENT FORM

The HIPAA Rules permit you, the patient, to request that your healthcare provider communicate with you via unsecured/unencrypted email and/or text messaging, if reasonable. In order to do so, HIPAA requires that your healthcare provider inform you of the risks involved.

## Risks of Transmitting Personal Health Information via Unsecured Email and/or Text Messages

Please use a ✓ by each possible risk outlined below showing that you have read it.
*Please note that the following outlined risks are not exhaustive.*

Emails/Texts May Be:

- ❏ circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients;
- ❏ misaddressed and sent to unintended recipient;
- ❏ read by employers, online services or other account holders;
- ❏ Intercepted, altered, forwarded or used without authorization or detection by a third party.

**I have read the aforementioned risks involved in transmitting my personal health information via unsecured email and/or text messaging. However, despite these risks, I request and authorize my healthcare provider, Dr. Amir Bajoghli, to communicate with me via unsecured email and/or text messages.**

***Email/Text Messages are not appropriate for urgent/emergency situations.**

**Patient's Email Address to be Used**: _____
*Please confirm and double check accuracy.*

**Patient's Cell Phone Number for Text Messages**: _____
*Please confirm and double check accuracy.*

Patient's Signature: _____

Print Patient's Full Name: _____ Date: _____

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Name:_____ Today's Date: (month)_____/(day)_____/(year)_____

## MEDICAL HISTORY

What is the reason for your visit today? _____

When did the problem begin? _____

What body locations are involved? _____

Is it associated with: ☐ Bleeding ☐ Itching ☐ Stinging ☐ Other _____

What have you used to the area so far and has it worked? _____

Have you been evaluated by another physician for this problem?_____

**PAST MEDICAL HISTORY**: (Please Circle ALL that apply)

| | | | |
|---|---|---|---|
| Anxiety | Diabetes | High Blood Pressure | Psychiatric condition |
| Arthritis | Kidney Disease | HIV | Peptic ulcer |
| Asthma | GERD (Acid reflux) | High Cholesterol | Radiation Treatment |
| Atrial fibrillation | Glaucoma/Cataracts | Hyperthyroidism | Seizures/Epilepsy |
| COPD (Emphysema) | Heart murmur | Hypothyroidism | Tuberculosis |
| Coronary Artery Disease | Hearing Loss | Liver disease | Joint Replacement |
| Depression | Hepatitis A/B/C | Pacemaker/Defibrillator | Stroke |

Other_____

Do you have a history of cancer? Yes / No If so, what type?_____

Have you had any surgical procedures? Yes / No If so, what type and the year that you had them?

_____ _____

_____ _____

**SKIN DISEASE HISTORY**: (Please Circle ALL that apply)

| | | |
|---|---|---|
| Acne | Eczema | Precancerous Moles |
| Actinic Keratosis | Flaking or Itchy Scalp | Psoriasis |
| Basal Cell Skin Cancer | Keloids | Squamous Cell Skin Cancer |
| Blistering Sunburns | Melanoma | Cold sores/fever blisters |
| Dry Skin | Poison Ivy | Other _____ |

Do you wear Sunscreen? Yes / No If yes, what SPF? _____Do you tan in a tanning salon? Yes / No

Do you have a family history of skin cancer? Yes / No If yes, what kind? Basal cell, Squamous cell, Melanoma, Other_____

Which relative(s)? _____

Do you have a family history of Vitiligo, Lupus, Psoriasis, or Eczema? Yes / No Which relative(s)? _____

Do you have a family history of Cancer, High Blood Pressure, Diabetes, Heart Disease, Kidney Disease, or Liver Disease?

Yes / No Which relative(s)? _____

**REVIEW OF SYSTEMS:** (Please Circle ALL that apply)

| | | | |
|---|---|---|---|
| Problems with healing | Hay fever symptoms | Abdominal pain | Headaches |
| Problems with scarring | Problems with bleeding | Bloody urine | Seizures |
| Fever or chills | Blurry vision | Bloody stool | Cough |
| Night sweats | Sore throat | Joint aches | Wheezing |
| Unintentional weight loss | Chest pain (right now) | Muscle weakness | |

**MEDICATIONS**: Please enter all current medications including over the counter medications (this includes vitamins, birth control pills, Ginseng, Gingko Biloba, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take antibiotics prior to procedures? Yes / No

**ALLERGIES**: (Please list all allergies)_____

**SOCIAL HISTORY**:

Are you pregnant/ lactating? Yes / No

Date of last menstrual cycle. _____

Do you have a history of **smoking** cigarettes? Yes/No Do you currently smoke? If so, how many packs per day? _____

Do you drink alcohol? Yes / No If so, how frequently? _____

Do you have any pets? Cats, Dogs, Birds, None, Other _____

What is your occupation? _____