51189 Shelby Parkway, Shelby Twp., MI 48315 (586) 997-9700 (586) 997-9738 Fax
1455 S. Lapeer Rd., Ste. 231 Lake Orion, MI 48360

PATIENT INFORMATION

PATIENT'S FULL NAME: _____ M/F (CIRCLE ONE)
IF PATIENT IS A CHILD: _____ _____
Mother's Name Father's Name
STREET ADDRESS: _____
CITY, STATE, AND ZIP: _____
PHONE #: (home) _____ (cell) _____ (work) _____
MAY WE LEAVE A MESSAGE? Home_____ cell_____ work_____ (please indicate yes or no)
DATE OF BIRTH: _____ MARITAL STATUS: _____ SOCIAL SECURITY NO: _____
E-MAIL: _____
RESPONSIBLE PARTY (IF PATIENT IS A MINOR): _____
ADDRESS (IF DIFFERENT FROM PATIENTS): _____
IN CASE OF EMERGENCY WHO SHOULD WE CONTACT: _____ NUMBER: _____
REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____
INSURANCE SUBSCRIBER: _____ RELATIONSHIP TO PATIENT: _____
SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER SOCIAL SECURITY NO: _____
SUBSCRIBER ADDRESS (IF DIFFERENT FROM PATIENT): _____
SUBSCRIBER PHONE NUMBER: _____ EMPLOYER: _____

SECONDARY INSURANCE NAME: _____
INSURANCE SUBSCRIBER: _____ RELATIONSHIP TO PATIENT: _____
SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER SOCIAL SECURITY NO: _____
SUBSCRIBER ADDRESS (IF DIFFERENT FROM PATIENT): _____
SUBSCRIBER PHONE NUMBER: _____ EMPLOYER: _____

I certify that the above information is correct. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in the information above. I request payment of authorized medical benefits to be made on my behalf to ACADEMIC DERMATOLOGY & COSMETIC SURGERY CENTER, PC, or Brian G. Sandler, M.D. I authorize any medical information needed to determine benefits payable to be released to my insurance company or its agent, including any complaints or appeals that need to be filed on my behalf. **I understand that I am financially responsible for all charges not paid by insurance. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** I also understand that should my insurance company issue payment to me for services rendered by this office, I am to forward payment to Academic Dermatology & Cosmetic Surgery Center. Further, I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____ _____
Signature of Patient (Patient Guardian) **Relationship to Patient** **Date**

MEDICAL INFORMATION

Please answer all questions by circling the right answer below.

CONCERNING ALLERGIES (IF YES, PLEASE LIST ALL)

DO YOU HAVE AN ALLERGY TO:

Medications or drugs	YES	NO
Ointments, creams or lotions	YES	NO
Make-up or jewelry	YES	NO
Insect bites	YES	NO

Other

_____

_____

_____

DO YOU OR ANYONE IN YOUR FAMILY SUFFER FROM:

Hayfever	YES	NO
Asthma	YES	NO
Sinus problems	YES	NO
Eczema	YES	NO

(If yes, please specify who has it.)

_____

_____

CONCERNING THE HEART & VASCULAR SYSTEM

DO YOU HAVE A HISTORY OF:

Heart disease	YES	NO
Blood pressure problems	YES	NO
Abnormal heart beat	YES	NO
Heart pacemaker	YES	NO
Heart murmurs	YES	NO
Rheumatic valve disease	YES	NO

CONCERNING YOUR LUNGS

DO YOU HAVE A HISTORY OF:

Bronchitis	YES	NO
Emphysema	YES	NO

CONCERNING YOUR INTERNAL ORGANS

DO YOU HAVE A HISTORY OF:

Stomach ulcers	YES	NO
Bowel disease	YES	NO
Liver disease	YES	NO
Diabetes	YES	NO
Kidney disease	YES	NO
Bladder infections	YES	NO
Vaginal infections	YES	NO
Prostatic disease or infections	YES	NO
Thyroid disease	YES	NO
Sexually transmitted disease	YES	NO

CONCERNING YOUR NERVES

DO YOU HAVE A HISTORY OF:

Seizures	YES	NO
Migraine headaches	YES	NO
Depression	YES	NO
Others:	YES	NO

_____

_____

CONCERNING YOUR BLOOD

DO YOU HAVE A HISTORY OF:

Anemia	YES	NO
Bleeding problems	YES	NO
Sickle cell disease	YES	NO
HIV/Aids	YES	NO
Hepatitis A B C (please circle)	YES	NO

CONCERNING YOUR SKIN

DO YOU HAVE A HISTORY OF:

Skin cancer	YES	NO
Lupus	YES	NO
Dermatomyositis	YES	NO
Connective tissue disease	YES	NO
Other skin diseases	YES	NO

(If yes, please list below.)

_____

_____

CONCERNING YOUR FAMILY

HAS ANYONE IN YOUR FAMILY HAD:

Heart disease	YES	NO
Diabetes	YES	NO
Skin Cancer	YES	NO
Other cancers:	YES	NO

_____

_____

CONCERNING YOUR SOCIAL ACTIVITIES

Do you drink alcoholic beverages? YES NO

(If yes, how many drinks a day?) _____

Do you smoke? YES NO

(If yes, how much?) _____

Please list the name of any medications you are currently taking-including vitamins and birth control

_____

_____

_____

_____

_____

_____

Please list the name and approximate date of any operations or injuries you have had.

_____

_____

Do you have a mental or physical disability? (List below)

_____

_____

FEMALE PATIENTS

Are you pregnant YES NO

Date of last menstrual period _____

_____ _____ _____

Signature of Patient (Patient Guardian) **Relationship to Patient** **Date**

51189 Shelby Parkway, Shelby Twp., MI 48315 (586) 997-9700 (586) 997-9738 fax
1455 S. Lapeer Rd., Ste. 231 Lake Orion, MI 48360

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____ _____

Signature of Patient (Patient Guardian) **Relationship to Patient** **Date**

INDIVIDUAL PATIENT AUTHORIZATION

This form is provided to confirm your authorization to use or disclose your protected health information for a special purpose.

Patient Name: _____
Address: _____
Phone Number: _____ Date of Birth: _____

I give my permission for my protected health information to be given as indicated below and as indicated in the Privacy Notice which has been given to me:

- ☐ Lab and other test results
- ☐ Diagnosis
- ☐ Information about my condition and or treatment
- ☐ All information can be given or discussed
- ☐ Other information described here _____

My information can be given only to the person or persons listed below.

_____
_____
_____
_____

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at the office. However, I understand that I may not revoke this authorization for any action taken prior to receipt of my written notice to revoke this authorization.

I have had a chance to read and think about the content of this authorization form and I agree with the statements made in this authorization. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

_____ _____ _____

Patient Signature/Patient Guardian Relationship to Patient Date

51189 Shelby Parkway, Shelby Twp, MI 48315 (586) 997-9700 (586) 997-9738 fax
1455 S. Lapeer Rd., Ste. 231 Lake Orion, MI 48360

CONSULTATION QUESTIONAIRE

NAME: _____ **DATE:** _____
Reason for Consultation: _____
Previous cosmetic procedures (please list): _____
_____

Pregnant or Nursing: YES NO Not Applicable

Interested in any of the following (please circle):

- Botox
- Fillers
- Liposuction
- Eyelid Rejuvenation
- Skin Care/Complexion Improvement
- Spider & Varicose Vein Treatment
- Microdermabrasion
- Laser Hair Removal
- Mini Face Lift
- Laser Resurfacing
- Chemical Peels
- Microneedling (Collagen P.I.N.)

Any other areas of concern: _____
_____

Thank You!

ACADEMIC DERMATOLOGY & COSMETIC SURGERY CENTER
INSURANCE POLICIES & FINANCIAL AGREEMENT

Payment is required for all services at the time they are rendered. For those patients, applicable co-payments, deductibles and co-insurance amounts will be collected prior to seeing our provider. We are required by your insurance carrier to collect these balances. These are not fees that we determine, but are in fact set and determined by your insurance carrier. These fees do not mean that your insurance carrier did not or will not cover your visit but are approved services by your insurance carrier and are the patient's out-of-pocket responsibility.

Our office appreciates that insurance matters may be confusing. Therefore, a member of our billing office will meet with you prior to any services rendered to inform you of your cost responsibility. This amount is due prior to services being performed. We will attempt to be as accurate as possible in the amount that you owe. However, once the claim has been filed there may be additional fees owed or you may have a refund coming back to you. Please note, that all refunds will be credited to your account promptly.

What is an Insurance Copay, Deductible or Co-Insurance

What is a copay?

A copay (or copayment) is a flat fee that you pay on the spot **each time you go to your doctor**. For some carrier's the copay amount is higher when seeing a specialist. The amount you pay for that visit is your copay. Your copay amount may be printed right on your insurance card. Copay's cover your portion of the cost of a doctor's visit or medicine.

What is a deductible?

A deductible is the amount you pay each year for eligible medical services or medicines *before* your insurance plan kicks in. For example, if you have a $1,000 yearly deductible, you are obligated by your insurance carrier to pay the first $1,000 of your total eligible medical costs before your insurance carrier will pay their percentage.

What is coinsurance?

Coinsurance is a portion of medical cost that you pay when your health plan kicks in. Your plan kicks in after you have paid your required deductible. Coinsurance is just a way of saying that you and your insurance carrier each pay a share of eligible costs to add up to 100%. For example, after your copay is paid, and after your deductible is met, you may still be liable for a percentage of the charge if your plan has a co-insurance. Your insurance company may only pay 70-80% of the remaining balance, leaving you responsible for 20-30%. Check with your insurance company or your employer to see if your plan has a co-insurance in addition to a copay and deductible.

Office Visit vs. Procedures

An office visit is defined as the examination and consultation with our provider. Any procedures performed in our office carry additional charges above the office visit charge. It is the patient's responsibility to inquire about the additional cost before the procedures are performed. It is also the patient's responsibility to obtain referrals when needed.

Payment options & Service Fees

Our office accepts cash, debit cards, most major credit cards and CareCredit. We also accept checks on statement balances only. Please note that there is a $35 service fee on all returned checks. Should our office have to send you a statement for services rendered, interest fees of 10% each month will incur if a balance remains unpaid after 60 days. Collection fees of 30% will incur if a balance remains unpaid after 120 days.

Missed Appointments: We require notice of cancellations 24 hours in advance. Failing to do so may result is a $30.00 missed appointment fee. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fee: Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

Miscellaneous Forms, Additional Information and Authorizations: We will provide all necessary information to have your benefits released. However, if it becomes necessary to submit redundant or unnecessary information for the completion of claim forms for work, school, sports, or extracurricular activities there will be an administrative fee, not to exceed $35.00, for additional information.

I have read the above Acknowledgements and Agreements and fully understand the same.

Signature of Patient/Patient Guardian)	Relationship to Patient	Date

51189 Shelby Parkway, Shelby Twp., MI 48315 (586) 997-9700 (586) 997-9738 Fax
1455 S. Lapeer Rd., Ste. 231 Lake Orion, MI 48360

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/13/03 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved on your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.