WELCOME TO OUR OFFICE. PLEASE TAKE A MOMENT TO COMPLETE THIS FORM IN ITS ENTIRETY.

LAST NAME FIRST INT	SEX M F	D.O.B.
STREET ADDRESS CITY/ STATE/ ZIP	HOME PHONE	CELL PHONE
PATIENT'S OR PARENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	BUSINESS PHONE
DO YOU HAVE A PRIMARY CARE PHYSICIAN? Y N IF YES, WHO?		
SPOUSE'S EMPLOYER	OCCUPATION	BUSINESS PHONE
EMAIL ADDRESS:	***REFERRED BY: HOW DID YOU HEAR ABOUT OUR OFFICE***	

PERSONAL INFORMATION

INSURANCE INFORMATION

INSURED /PARTY RESPONSIBLE	ADDRESS (IF DIFFERENT FROMPATIENT)	RELATIONSHIP	INSURED'S DATE OF BIRTH SS# IF NECESSARY)
PRIMARY INSURANCE COMPANY	GROUP NUMBER	MEMBER ID NUMBER	
SECONDARY INS COMPANY/ NAME OF INSURED	GROUP NUMBER	MEMBER ID NUMBER	

PREFERRED PHARMACY	LOCATION	PHONE NO (IF AVAILABLE)

EMERGENCY CONTACTS
PLEASE LIST BELOW SOMEONE WE MAY CONTACT IN CASE OF AN EMERGENCY

NAME	PHONE NUMBER	RELATIONSHIP
NAME	PHONE NUMBER	RELATIONSHIP

CURRENT PROBLEM

BRIEFLY STATE YOUR PROBLEM. DO YOU HAVE ANY SYMPTOMS LIKE BURNING OR ITCHING ASSOCIATED WITH IT?		
HOW LONG HAVE YOU HAD THIS?	HAVE YOU HAD IT BEFORE? IF SO, WHEN	HAVE YOU BEEN TREATED FOR THIS BEFORE?

HISTORY AND INTAKE FORM

Medical History:

- ☐ Anxiety
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ Depression
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Other Cancer _____
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement

Other _____

Past Surgical History:

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ PTCA
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee
- ☐ Joint Replacement within last 2 yrs
- ☐ Kidney Biopsy
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP
- ☐ Skin Biopsy
- ☐ Basal Cell Cancer Surgery
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Melanoma Surgery
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer

Other _____

Family History:

- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Other Cancer _____
- ☐ Prostate Cancer
- ☐ Seizures
- ☐ Stroke

Other _____

Are you currently pregnant? ☐ Yes ☐ No If yes, how long? _____

Number of Pregnancies _____ Miscarriages _____

Are you post- menopausal? ☐ Yes ☐ No If yes, how long? _____

Skin Disease History:

- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Acne
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Eczema
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Squamous Cell Skin Cancer
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Skin Discoloration (Darkening)

Other: _____

Do you wear sunscreen daily: ☐ Yes ☐ No If yes, what SPF? _____
Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a **family history** of: ☐ Melanoma If so, which relative(s)? _____
☐ SCC/BCC If so, which relative(s)? _____

MEDICATIONS: *(Please list all current medications)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

SUPPLEMENTS: *(Please list all current supplements)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

ALLERGIES: *(Please enter all allergies)*

_____ _____ _____
_____ _____ _____

SOCIAL HISTORY:

- ☐ Currently Smokes – daily
- ☐ Currently Smokes – not daily
- ☐ Previous Smoker - Year Stopped _____
- ☐ Never smoked
- ☐ Alcohol Use: _____ Daily _____Social
- ☐ Illicit Drug Use
- ☐ NONE

Other _____

REVIEW OF SYSTEMS (PLEASE CHECK ALL THAT APPLY):

- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic/keloid)
- ☐ Immunosuppression
- ☐ Changing mole
- ☐ Rash
- ☐ Abdominal pain
- ☐ Anxiety
- ☐ Blood stool
- ☐ Bloody urine
- ☐ Blurry vision
- ☐ Chest pain
- ☐ Cough
- ☐ Depression
- ☐ Depression
- ☐ Fever or chills
- ☐ Headaches
- ☐ Hay fever
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Night sweats
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Thyroid problems
- ☐ Unintentional weight loss
- ☐ Urinary Incontinence
- ☐ Discomfort during Intercourse
- ☐ Vaginal Dryness
- ☐ Wheezing

PATIENT SIGNATURE_____ **DATE**_____

DR ROSE_____ **DATE**_____

Are you interested in our cosmetic skin care products or services? Yes No

PLEASE READ CAREFULLY

I UNDERSTAND THAT DR. ROSE DERMATOLOGY PARTICIPATES WITH CERTAIN INSURANCE CARRIERS. UNLESS A CONTRACTUAL ARRANGEMENT EXISTS BETWEEN DR. ROSE AND MY INSURANCE COMPANY, I AGREE TO PAY THE FEES IN FULL, EVEN THOUGH THE AMOUNT MAY BE GREATER THAN WHAT I AM ENTITLED TO RECEIVE FROM MY INSURANCE CARRIER. ANY CO/PAYS, DEDUCTIBLES, OR AMOUNTS DEEMED PAYABLE BY MY INSURANCE CARRIER SHALL BE MY RESPONSIBILITY. BALANCES REFLECTED ON THE OFFICE BILL, WHICH IS NOT EXPECTED TO BE REIMBURSED BY INSURANCE, SHALL BE PAYABLE BY ME. PROCEDURES DEEMED "COSMETIC", BY ANY INSURANCE CARRIER, WILL BE MY RESPONSIBILITY. THERE IS A $25.00 FEE FOR ALL UNPAYABLE CHECKS. *IT IS YOUR RESPONSIBILITY TO BE FAMILIAR WTH YOUR INSURANCE POLICY FOR GENERAL COVERAGE ISSUES.*

SIGNATURE_____ **DATE** _____

AN IMPORTANT MESSAGE REGARDING MOLES AND MELANOMAS

THE INCIDENCE OF MALIGNANT MELANOMA IS ON THE RISE. IN EFFORT TO IDENTIFY AND TREAT THIS CONDITION, IT IS RECOMMENDED THAT A TOTAL SKIN OR DERMATOLOGICAL BODY EXAM BE PERFORMED. BY VISUAL EXAMINATION OF MOLES, ON THE SKIN, WE CAN EVALUATE THE STATUS OF THOSE LESIONS AND DETERMINE IF TREATMENT IS NEEDED AT THIS TIME,

NO ONE KNOWS WHAT THE STIMULUS IS FOR SUCH LESIONS TO UNDERGO MALIGNANT CHANGES. VARIOUS FACTORS SUCH AS SPORADIC SUN BURNS, PROLONGED SUN EXPOSURE, TRAUMA, FRICTION, HORMONAL INFLUENCES AND HEREDITY HAVE BEEN INVOLVED IN THE DEVELOPMENTOF MALIGNANT CHANGES (CALLED MELANOMA). BECAUSE OF THE RAPID EVOLUTION OF MELANOMAS, IT IS OF THE UTMOST IMPORTANCE THAT QUICK AND EARLY DIAGNOSIS BE MADE. TREATMENT MUST BE DONE TO REMOVE SUCH A LESION ENTIRELY AND THOROUGHLY. CURRENTLY, PROGRESS IS BEING MADE IN THE CHEMICAL TREATMENT OF THOSE PATIENTS WHOSE DISEASE HAS SPREAD TO OTHER PARTS OF THE BODY; HOWEVER THE BEST HOPE IS FOR EARLY DIAGNOSIS AND REMOVAL.

DERMATOLGISTS ARE TRAINED TO CLINICALLY RECOGNIZE THE TYPES OF CHANGES THAT TAKE PLACE IN MELANOMA AND ARE KNOWLEDGEABLE OF THE MICROSCOPIC ASPECTS OF THIS CONDITION. APPROACHES IN TREATMENT OF SUCH LESIONS ARE IN THE FOREFRONT OF GOOD DERMATOLOGICAL PRACTICE. ANY CHANGE WHATSOEVER IN A MOLE SHOULD BE CAREFULLY EVALUATED BY A DERMATOLOGIST.

ACCORDINGLY, THIS DERMATOLOGICAL PRACTICE IS OFFERING TO PATIENTS TOTAL BODY DERMATOLOGICAL EXAMINATION WITH APPROPRIATE RECOMMENDATIONS. THIS WILL INCLUDE A FULL HEAD-TO-TOE SURVEY OF THE ENTIRE SKIN. ANY SUSPICIOUS LESIONS CAN AND WILL BE REMOVED. THAT TISSUE WILL BE SENT FOR HISTOLOGICAL EXAMINATION BY A BOARD CERTIFIED DERMOPATHOLGIST WHO WILL BILL YOU DIRECTLY. THE USUAL SUGICAL FEES WILL BE APPLIED FOR SUCH SERVICES IN THIS OFFICE.

ON THIS VISIT TO OUR OFFICE TODAY WE EXTEND TO YOU THE OPPORTUNITY TO HAVE THE ABOVE NOTED DERMATOLOGICAL EXAMINATION PERFORMED ON YOU. BECAUSE OF THE IMPORTANCE OF THIS VERY SERIOUS CONDITION, WE RECOMMEND THAT IT BE DONE.

PLEASE SIGN AND DATE THIS FORM ACKNOWLEDING WHETHER OR NOT YOU WISH TO HAVE THIS PROCEDURE PERFORMED.

_____ YES, I WISH TO HAVE THE EXAMINATION PERFORMED.

_____ NO, I DO NOT WISH TO HAVE THE EXAMINATION PERFORMED.

_____ _____

SIGNATURE DATE

ACKNOWLEDGEMENT OF RECEIPT
HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT NAME:	DATE OF BIRTH:

Rose Dermatology & Laser Center has offered a copy or provided a copy of the Notice of Privacy Practices, which completely describes uses and disclosures. I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting our office or on rosedermatology.com website. I understand that at any time I have the right to revoke this consent provided that I do so in writing. Rose Dermatology and Laser Center may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Rose Dermatology and Laser Center may refuse you service if you refuse to sign the consent.

_____ Initial — I hereby authorize Rose Dermatology & Laser Center to leave voice, text and/or email messages to confirm appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments.

_____ Initial — I hereby authorize that Rose Dermatology & Laser Center may disclose my personal health information to the person(s) who I have listed as my emergency contact.

_____ Initial — I hereby authorize that Rose Dermatology & Laser Center may disclose my personal health Information to the following person(s):

NAME	TELEPHONE NUMBER	RELATIONSHIP TO PATIENT

_____ Initial — Any member of my immediate family.

If any of the above information changes, it is the Patient/Parent/Legal Guardian/Personal Representative's responsibility to contact our office.

I acknowledge that I have read, or had the opportunity to read if I choose, and understand the Notice of Privacy Practices.

_____ Signature of Patient/Parent/Legal Guardian/ Authorized Representative

_____ Printed Name

_____ Date

If Authorized Representative signature, please indicate legal authority _____.

FOR OFFICE USE:

Changes to above authorized by patient over phone:

CHANGE	DATE	STAFF INITIALS

NOVEMBER 2016

Date: _____ ROSE DERMATOLOGY

We value you as a patient and are happy to provide medical services to you. It is our responsibility to inform you of our office policy.

- **For Medicare Patients Only:** (Please do not sign if you do not have Medicare) By signing, I request that payment of authorized Medicare benefits be made to Rose Dermatology and Laser Center for any services provided to me by the physician. I authorize the release of my medical information to the Health Care Financing Administration and its agents to determine the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of HCFA 1500 claim form is completed, my signature authorizes releasing of the information to the insurers or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and **THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, COINSURANCE AND NON COVERED SERVICES.** Coinsurance and deductible are based upon the charge determination of the Medicare carrier.
  Patient/Medicare Beneficiary Signature: _____

- **Secondary Insurance:** By signing, I authorize and direct my insurance carrier to pay directly to Rose Dermatology and Laser Center. I further agree to pay the balance of the charges not paid by my insurance. Any balance that is not paid within 45 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits.
  Signature: _____

- FOR NON MEDICARE PATIENTS
  Financial Payments: By signing, I understand that a co-payment, deductible and/or coinsurance may apply to EVERY visit according to the terms and conditions of my insurance plan. I understand that even though I have insurance coverage, I am responsible for payment for services that are not covered by my insurance plan. I understand that if my insurance information is incorrect, I will be responsible for payment of the visit and to submit charges to the correct plan for reimbursement.

  Signature: _____

  Copay: I agree to take full financial responsibility for payment of my copay. I understand that my copay amount is determined by my insurance plan benefit and the amount I am charged will be for services rendered by a specialist. I **understand that payment of my copay will be required at the time services are rendered.**
  Initial: _____

  Deductible: I agree to take full financial responsibility for payment of my deductible. I understand that my deductible amount is determined by my insurance plan benefit. I understand that the amount I am charged will be for services rendered by a specialist according to the fee schedule of my insurance plan. **I understand that payment of my deductible will be required at the time services are rendered.**
  Initial: _____

  Coinsurance: In the event that a coinsurance applies, I understand that I will be billed for any amount that my insurance company determines to be my responsibility. I agree to take full financial responsibility for payment of my coinsurance.
  Initial: _____

- **Referrals/Authorization**
  By signing, I understand that it is my responsibility to know if my insurance plan requires a referral to see a specialist or whether or not preauthorization is required and what services are not covered. I understand that if my plan requires a referral to see a specialist, it is my responsibility to obtain a referral from my primary care physician. In the event my referral is invalid due to an expiration date, exceeded number of visits or terminated coverage, I understand that I will be responsible for full payment for the services rendered.

  Signature: _____

PATIENT NAME: _____ D.O.B.: _____

ROSE DERMATOLOGY & LASER CENTER

CANCELLATIONS, NO SHOWS AND LATE ARRIVALS

Thank you for trusting your medical care to Rose Dermatology & Laser Center. We strive to render excellent medical care to you, your family, and all of our patients. In order to be consistent with this philosophy, this practice uses an appointment system that allows ample time for a patient dependent on patient's needs.

If you do not show up for your appointment, or notify us of your inability to keep your appointment ***at least 24 hours in advance***, the time allotted cannot be used to treat another patient in need. With that in mind, a Medical Appointment Policy has been put into place.
Our policies are as follows:

LATE CANCELLATIONS:

Appointment cancellations require at least a 24 hour advance notice. We understand that often appointments need to be cancelled at the last minute. However, this should be the exception and not the rule.

When you call to cancel an appointment, please make note of the time, date and person with whom you spoke. Should you cancel your appointment with less than 24 hours' notice, you will be charged a **$50 fee.** This is a non-covered expense by your insurance company and you will be responsible for the charge.

NO SHOW APPOINTMENTS:

Many patients schedule an appointment and do not show up, nor do we receive a phone call to cancel that appointment. Segments of time are blocked off for each patient. When these patients do not show up or call to cancel, they deprive another patient the opportunity to be seen. Patients that fail to present for their appointment, will be a charged a **$120 fee.** This is a non-covered expense by your insurance company and you will be responsible for the charge. Patients that fail to present for a scheduled appointment more than three times may be dismissed from the Practice.

Laser patients that fail to show up for their appointment will be charged the **full price of the procedure scheduled.**

LATE ARRIVALS

Patients arriving late for their appointments will most likely need to reschedule their appointment. ***Late arrivals affect the remainder of the schedule for that day.*** Please do not assume that it is OK to arrive late because the doctor/ laser tech is probably running late too. Patients must come in at the designated time for their appointments. You may be asked to reschedule your appointment. Late arrivals may affect your scheduled allotted time for the laser treatment desired.

CONFIRMATIONS

We do provide ***courtesy*** emails, phone calls and text messages to remind patients of appointments in sufficient time for you to cancel if necessary. Please dial **504-885-8363** to cancel or reschedule your appointment if necessary. These reminders are sent according to your signed HIPAA consent. It is **your responsibility** to cancel or reschedule any pending appointments in accordance with these policies.

By signing this **Cancellation, No Show** and **Late Arrival** policy you agree to the terms of the policies stated above and the associated fees imposed.

Patient Signature: _____ Date: _____