PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. The federal Government requires the following notification regarding privacy.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Office Manager.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:____

Signature_________________________________ Date:__________

Dear Patient,

Dr. Rosenbach provides what he feels is the best care that is appropriate for your health or health maintenance. This letter is to inform you that although these services are important for maintaining or assuring you optimum health, they may not be covered by your insurance company.

Your insurance carrier may use the terms “medically unnecessary”, “routine”, “not covered”, or “preventive care” to deny coverage for certain services including routine exams, laser treatments, injections, and laboratory tests. Furthermore, carriers may claim to cover “routine care” but this “coverage” may not be as comprehensive as you expect.

Since there is no consistency amongst the multitude of insurance carriers, my office cannot keep up with which carriers cover which services. Although we can help you by corresponding with your insurance carrier to appeal denied claims, we cannot predict the outcome of the claim reviews. You may want to check with your carrier prior to being seen to verify that coverage is available for expected services.

Your signature verifies that you understand that services provided may not be covered by your policy and that you are financially responsible for these services even if deemed unnecessary or unpayable by your carrier.

AUTHORIZATIONS:

Authorization to Pay Benefits to Physician:

I hereby authorize payment directly to the above named physician of the surgical and/or medical benefits, if any, otherwise payable to me for his services as described on attached claim, this may not represent the full payment of services rendered and I will be responsible for the balance due. I also hereby authorize above named physician to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of evaluation for payment.

Signed:___________________________

Print Name:__________________________

Date:______/______/_____

ALAN **ROSENBACH, M.D.** *Laser Surgery • Dermatology*

Last Name:___________________________________

DATE: _____/_____/_____

First Name:______________________________ **Middle Name:** ______________

Sex**:** ***Male or Female (Circle)*** **Date of Birth:**_____/_____/_____

Age:______

Billing Address:____

City:________________ **State:**_____ **Zip:**____________

Country:________________

Home Phone: (_____ **)** ______-________

Message Phone #: (_____ **)** ______-________

E-Mail Address: ____

Social Security #:_______-______-______

Marital Status: *Single* *Married* *Separated* *Divorced* *Widowed*

Emergency Contact:____

Emergency Contact Phone: (_____ **)** ______-________

Referred By:____

Family Doctor:____________________ **Dermatologist:**_____________________

Occupation:_________________________ **Employer:**________________________

Employer Address:____

Employer Phone: (_____ **)** ______-________ **Ext:**_______

MEDICAL INSURANCE PLANS:

Primary Insurance Name & Address: ____

____

Subscriber:_______________________ **Group #:**_________________________

Cert#:_____________________

IF YOU ARE UNDER THE AGE OF 18 OR UNDER THE CARE OF A LEGAL GUARDIAN:

Responsible Party Name:__________________________________

Responsible Party Address:____

Responsible Party Home Phone: (_____) ______-________

Responsible Party Social Security #: _______-______-________

MEDICAL HISTORY:

Reason for Consultation: ____

____

____

Previous Serious or Chronic Illness: ______________________________________

Previous Operations: ____

List Present Medications: ____

Drug Allergies: ____

Cosmetic Procedures

(e.g., chemical peels, collagen, sclerotherapy, plastic surgery, etc. – include dates)

____

What Brands of Cosmetic Products Do You Use

(e.g. soaps, moisturizer, glycolic, eye cream, etc?

____

Do You Take Aspirin Regularly? *Yes or No*

Have You Ever Taken Accutane? *Yes or No* **Date Stopped?** ____/____/____

Have You Ever Taken Cortisone? *Yes or No* **Date Stopped?** ____/____/____

Do You Have or Have You Ever Had, Any of the Following?

If So, Please Give Dates & Details:

Easy Bruising/Bleeding Tendencies?	*No or Yes*	____________________
Asthma?	*No or Yes*	____________________
Poor Healing or Unsightly Scarring?	*No or Yes*	____________________
Emphysema?	*No or Yes*	____________________
High Blood Pressure?	*No or Yes*	____________________
Heart Disease?	*No or Yes*	____________________
Liver Disease?	*No or Yes*	____________________
Kidney Disease?	*No or Yes*	____________________
Skin Cancer?	*No or Yes*	____________________
Melanoma?	*No or Yes*	____________________

Are you currently Pregnant or Breast Feeding? ***Yes or No***

List immediate family members that have been diagnosed with skin cancer:

____

Has any family member been diagnosed with malignant melanoma?

No or Yes ____________________ *Relationship:* ______________________

Financial Policy

Payment is expected as services are rendered. We accept cash, checks, AMEX, VISA, and MasterCard. We also provide a 90 day interest-free credit through third-party financing upon request, and subject to qualification.

For those patients covered by insurance, we are happy to extend the courtesy of billing your insurance company for reimbursement to you. However, in order to provide this service to you, we must have complete insurance information. It is your responsibility to fill out the necessary forms that give us all the insurance information required.

For more extensive treatments if a pre-determination of insurance benefits is processed, you are then responsible for the co-payment at the time of service. If we do not receive payment from your insurance company within 30 days of billing them, the balance will become your responsibility. The insurance agreement is between you and your insurance company, and you will be expected to contact them directly if a problem arises. If you still have billing questions please call our office and ask for assistance.

For all accounts beyond 45 days with amounts due, there will be a $10 billing fee or a financing charge of 1.5% per month, whichever is greater.

We assign all accounts over 120 days to a collection service for processing.

Sincerely,

Alan Rosenbach, M.D.

I understand that I will be charged $50.00 if I fail to keep an appointment or if I do not notify the office of my cancellation by 3:00 p.m. the day before a scheduled appointment. I understand if my appt is for any laser procedure a 48 hour cancellation is required.

Should this account become past due, I agree to pay any reasonable additional fees, including any and all collection agency charges, legal fees and/or court costs, necessary to collect this account.

I agree to this financial policy, and I have read and received a copy of this document.

Signature___________________________________ **Date**_______________

Patient Name ________________________________ **Date** ______________

Patient Skin Care and Cosmetic Surgery

New technologies have expanded the range of products and procedures available to enhance the appearance of your skin and body. To help us provide you with services you desire and the best treatment possible, please answer the following questions regarding your skin care and cosmetic needs.

Skin Care

Please indicate which of the following concerns you may have about your general skin care needs. (check as many as apply)

◻ Acne Prone Skin
◻ Spider Veins
◻ Sunspots: Face, Arms and Chest
◻ Skin Cancer
◻ Facial Vessels/Red Facial Discoloration
◻ Aging Skin
◻ General Skin Care (cleansing, moisturizing, etc.)
_ Dry Skin
◻ Excess Facial/Body Hair
◻ Scar Treatment
◻ Other ____

Skin Care & Cosmetic Services

The following is a list of the various services we provide to our patients. Please indicate the procedure(s) you would like to discuss with Dr. Rosenbach.

◻ Face, Neck and Chest Rejuvenation
◻ Hair Removal
◻ Facial Vessels/Red Facial Discoloration
◻ Schematic Botox
◻ Skin Resurfacing and Wrinkle Reduction
◻ Glycolic Peels
◻ Sunspots: Face, Arms and Chest
◻ Melanomography
◻ Scars and Stretch Marks
◻ Sclerotherapy
◻ Medical-Grade Microdermabrasion
◻ Mole Removal