

Patient Demographic Form

Last Name: _____ First Name: _____ Middle _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Sex: F ___ M ___ Email: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

SS#: _____ Employer: _____ Occupation: _____

Spouse's Name: _____ Phone: _____ Date of Birth: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Family Doctor Name/Address: _____ Phone: _____

Pharmacy Name/Address: _____ Phone: _____

How were you referred: TV INS YP RADIO FRIEND INTERNET OTHER _____

(DO NOT FILL OUT INSURANCE SECTION BELOW FOR WEIGHT LOSS OR AESTHETICS SERVICES)

INSURANCE INFORMATION

Primary: _____ Secondary: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

ID#: _____ Grp# _____ ID#: _____ Grp# _____

Insured Name: _____ DOB: _____ Insured Name: _____ DOB: _____

NOTE: If your insurance requires a referral or authorization for office visits, it is your responsibility to obtain this prior to your visit.

ASSIGNMENT OF BENEFITS:

I hereby authorize payment directly to Understanding Women, Thomas Laser Center and Laser Surgery Center for all services rendered. I hereby authorize Understanding Women, Thomas Laser Center and/or Laser Surgery Center to release any information required to determine medical benefits payable for services to the organization, the Health Care Financing Administration my insurance carrier or other medical entity. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Signed: _____ Date _____

Financial Policy

Thank you for choosing our office. We welcome you! We are committed to providing the finest care and professionalism for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our billing personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. **You will be responsible for all co-pay, coinsurance, and deductibles on the day of service.** Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled please be aware there will be a **Physician, Facility, Anesthesia and Lab fee**. We will submit for the Physician and Facility. If a procedure is generally deemed to be "cosmetic" or "non medically necessary", we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MC, Discover or cash.

All insurance information, including prior authorizations and referral forms, must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.

Delinquent accounts over 90 days will be subject to the following action. A collection-processing fee will be added to your outstanding balance and turned over to our collection agency Bureau of Medical Economics for further processing.

FEES: There will be a \$40 fee for the following: Electronic copy of medical records to a patient or insurance company.

There will be a \$50 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers check, money order, certified check or cash).

If you need to cancel a scheduled appointment, please contact our office at least **72 business hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A FEE WILL BE ASSESSED DEPENDING ON THE LEVEL OF COMPLEXITY FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 72-BUSINESS HOURS ADVANCE NOTICE.**

REFUNDS FOR AESTHETIC SERVICES: All treatments (Single and/or packages) are Non-Refundable. Unused pre-paid treatments are not eligible for a refund but you may apply the credit toward future services or product.

PRODUCTS PURCHASES: Products are Non-Refundable or Exchangeable.

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon patient's request.

Print Name

Signature of responsible party

Date

Patient Communication Authorization

Patient's Name: _____ Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It's okay to call:

_____ Home phone number Leave a message: __ yes __ no

_____ Mobile/Cell number Leave a message: __ yes __ no

_____ Work phone number Leave a message: __ yes __ no

_____ Call only this number. _____ Leave a message: __ yes __ no

_____ Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

_____ This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature _____ Date _____

MEDICAL HISTORY

Patient Name: _____ Marital Status: _____ Age _____ D.O.B: _____

Reason for today's visit: _____

Drug Allergies: _____

Are you allergic to Latex: Yes No Hepatitis: Yes No HIV: Yes No

<u>Past Medical History</u>	<u>Past Surgical History/Year</u>	<u>Family History</u>	<u>Family Member</u> (Immediate)	<u>Current Medication/Vitamins</u> <u>Name/Dosage</u>
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Gallbladder _____	<input type="checkbox"/> Heart Disease	_____	<u>SEE LIST</u>
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hemorrhoids _____	<input type="checkbox"/> Breast Cancer	_____	_____
<input type="checkbox"/> Long term steroid use	<input type="checkbox"/> Hysterectomy _____	<input type="checkbox"/> GYN Cancer	_____	_____
<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Surgery _____	<input type="checkbox"/> Blood clots in	_____	_____
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Pace maker _____	lungs or legs	_____	_____
<input type="checkbox"/> Stroke	<input type="checkbox"/> Defibrilator _____	<input type="checkbox"/> Colon/Bowel Cancer	_____	_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Prostate _____	<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Cholesterol disorder	<input type="checkbox"/> Bowel Surgery _____	<input type="checkbox"/> Prostate Cancer	_____	_____
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Tubal ligation _____	<input type="checkbox"/> Other _____	_____	_____
<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Thyroid Surgery _____	_____	_____	_____
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> C-section _____	_____	_____	_____
<input type="checkbox"/> Lupus/Autoimmune Dis	<input type="checkbox"/> Bariatric Surgery _____	_____	_____	_____
<input type="checkbox"/> Gout	<input type="checkbox"/> Cosmetic(type) _____	_____	_____	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	_____	_____	_____

Social History:

Other _____ Tobacco use: Everyday Some days Former Never

Chief Complaint and Review of Systems

- | | |
|---|--|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Menopausal symptoms |
| <input type="checkbox"/> Anal itch | <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> Anal pain | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Anal warts | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rectal drainage |
| <input type="checkbox"/> Bladder control problems | <input type="checkbox"/> Screening Colonoscopy |
| <input type="checkbox"/> Breast mass/discharge | <input type="checkbox"/> Unable to hold bowels |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Unable to hold gas |
| <input type="checkbox"/> Fatigue/tired/sluggish | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Heavy vaginal bleeding | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hemorrhoids | _____ |
| | _____ |

GYN History:

- How many pregnancies: _____
- Are you pregnant: _____
- Do you plan to become pregnant: _____
- Are you breast feeding: _____
- Date of last:**
- Menstrual Period: _____
- Pap Smear: _____
- Abnormal Pap: _____ Result: normal abnormal
Treatment: burning freezing laser
- Colonoscopy: _____ Result: normal abnormal
- Pelvic US: _____ Result: normal abnormal
- Endometrial Biopsy: _____ Result: normal abnormal
- Bone Density Scan: _____ Result: normal abnormal
- Mammogram: _____ Result: normal abnormal

Signature _____

Date _____

OFFICE USE ONLY

HT: _____ WT: _____ HGB: _____

BP: _____ P: _____ PREG TEST: _____