



Name: _____ Date of Birth: ____/____/____ Sex: _____

Street Address: _____

City: _____ Zip Code: _____ Social Security#: _____ - _____ - _____

Daytime phone number: () _____ - _____ Cell phone number: () _____ - _____

Marital status (check one): Single Married Divorced Widow

E-Mail Address: _____

Employer Information

Occupation: _____ Employer Name: _____

Phone number: () _____ - _____ City, State: _____

Emergency Contact Information

Name: _____ Home phone number: () _____ - _____

Work phone number: () _____ - _____ Relationship to patient: _____

Medical History

- Arthritis Glaucoma Thyroid Melanoma HIV+(exposure)
- Chronic cough Asthma/Bronchitis Chest pain Hepatitis A/B/C Heart Murmur
- Lymphoma Squamous Cell Basal Cell Diabetes Emphysema
- High Blood Pressure Cancer of breast/colon/prostate Mitral valve prolapse

Reason for today's visit: _____

Please list any other medical conditions we need to be aware of: _____

Please list any surgical procedures you've had within the last 6 months: _____

Please list any known allergies: _____

Please list all medications you are currently taking: _____

- Do you drink alcohol: Yes No Do you currently use/have used IV drugs? Yes No
- Do you smoke? Yes No Do you require antibiotics prior to surgery? Yes No
- Are you pregnant? Yes No Do you bleed easily? Yes No
- Are you latex intolerant? Yes No Do you have artificial joints/pins/screws? Yes No

Have you ever had dental anesthesia (Novocain)? Yes No Any adverse reactions? _____

Do you have any family history of skin cancer? Yes No If yes, what type? _____

Primary Care Physician: _____ Primary Care Phone Number: () _____ - _____

Preferred Pharmacy: _____ Pharmacy Phone Number: () _____ - _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____



PLEASE INITIAL

_____ I understand that medical care requires my cooperation. I agree to follow my doctor's orders and prescriptions. I will make and keep appointments for follow-up care and call the office to note any changes or concerns regarding my condition.

_____ I authorize my provider and JDHR to take photographs/video tape or by other similar means record my surgery/procedure(s). I understand that reproduction or publication of said photographs and recordings may be used for the purpose of medical/scientific study and research, education, before and after surgical portfolios of the body to demonstrate surgery/procedures, and that every effort will be made to protect the patient's identity in those materials. I further acknowledge that all recorded media obtained is the sole property of JDHR.

_____ I authorize my doctor to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child, during the period of such medical care to the third party payers, including Medicare. I authorize and request that my insurance company, in lieu or reimbursing me directly, pay to the doctor or medical group any benefits or services. I agree that I may be responsible for payment of all services rendered on my behalf of my dependents. I understand I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have contracted lab or facility, or if services are not covered by my insurance company.

_____ I understand that the doctors and staff of JDHR consist of male and female staff. I consent to having a male staff member in my examination room, perform my exam or treatment, and/or assist me in my medical care. I understand that I can request the assistance of a female staff member at any time.

Skin Care Questionnaire

1. Please check your skin type:

- Type I-Always Burn, Never Tan
- Type II-Always burn, Sometimes Tan
- Type III-Sometimes Burn, Always Tan
- Type IV-Never Burn, Always Tan
- Type V-Moderately Pigmented (Hispanic, Asian, Middle Eastern, or Mediterranean)
- Type VI- Black

2. Is your skin: Dry Oily Combination

3. Do you currently use sun block? Yes No Product Name: _____ SPF _____

4. Do you currently use Retin A, Tretinoin, or Renova for anti-aging? Yes No

5. Do you use any topical antioxidants? Yes No Product Name: _____

6. Are you interested in improving the appearance of your skin? Yes No

- Refreshed Wrinkles & Fine Lines Sagging Skin/Volume Loss Jowls Brown Spots Tone & Texture
- Pore Size Redness/Broken Blood Vessels Dryness Acne Pre-Cancerous Lesions

7. Do you or have you had facial treatments done? Yes No

8. Check which treatment you have had done previously and date of last treatment:

- Facials Microdermabrasion Chemical Peels Laser
- Botox Fillers (Sculptra, Radiesse, Restylane, Perlane, Juvederm) None

9. List Allergies _____

I am interested in obtaining more information on the following:

- | | |
|--|---|
| <input type="checkbox"/> Facial Fillers (Radiesse, Restylane, Perlane, Juvederm)
___ Moderate to severe facial wrinkles and folds | <input type="checkbox"/> CO2 Resurfacing Laser/ Ultra Pulse
___ Anti-aging skin resurfacing treatment |
| <input type="checkbox"/> Sculptra (Virtual face lift)
___ to improve facial volume
___ To improve sagging skin | <input type="checkbox"/> Botox or Dysport
___ Improve the appearance of wrinkles brow lines
___ Underarm sweating |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> IPL Photo Facial Rejuvenation
___ To improve pigmentation and redness |
| <input type="checkbox"/> Vein Therapy/ Sclerotherapy
___ Eliminate spider and varicose veins | <input type="checkbox"/> BluLight
___ Pretreat cancer lesions |
| <input type="checkbox"/> Skin Care
___ Chemical Peels
___ Microdermabrasion
___ Facials | <input type="checkbox"/> Hair Care/ Hair Loss/ Hair Transplant Surgery

<input type="checkbox"/> Colorescience Mineral Makeup |

**PATIENT CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)
ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided with **Jupiter Dermatology & Hair Restoration**, "Notice of Privacy Practices", and I am giving my consent for the use and disclosure of Protected Health Information as required and / or permitted by law.

Patient Name:

(please print)

Patient Signature

(or legal representative; proof may be requested)

Date:

EMAIL, MOBILE TEXT & VOICE MESSAGE CONSENT FORM

Purpose: This form is used to obtain your consent to communicate with you by email, mobile text & voice messaging regarding your Protected Health Information. **Jupiter Dermatology & Hair Restoration, (JDHR)** offers patients the opportunity to communicate by email, mobile text & voice messaging. Transmitting patient information by email, mobile text & voice messaging has a number of risks that patients should consider before granting consent to use email, mobile text & voice messaging for these purposes. **JDHR** will use reasonable means to protect the security and confidentiality of email, mobile text & voice messaging information sent and received; however, **JDHR** cannot guarantee the security and confidentiality of email, mobile text & voice messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email, mobile text & voice messaging between **JDHR** and me and consent to the conditions outlined herein. Any questions I may have had were answered.

Patient Acknowledgment & Agreement

My Consented Email Address is:

My Consented Mobile Number For Voice & Text Messaging is:

X _____

Patient Signature

Date

A: Notifier: Group M Dermatology dba Jupiter Dermatology & Hair Restoration

B: Patient Name: _____ **C: DOB:** _____

Advance Beneficiary Notice of NonCoverage (ABN)

NOTE: If _____ (insurance co.) doesn't pay for the **D:** _____ (treatment(s)) below, you may be responsible for payment. Insurance companies do not pay for everything, even some care that you or your healthcare provider have good reason to think you need. Insurance authorization is not a guarantee of payment.

D. TREATMENT (list CPT & DX codes here)	E. Reason Insurance May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Insurance Companies cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the **D.** _____ listed above. I want *Insurance* to be billed for an official decision on payment, which will be sent to me on an Explanation of Benefits (EOB). I understand that if *Insurance* doesn't pay, I am responsible for payment. I understand that I can appeal following insurances guidelines and if my insurance does pay, Jupiter Dermatology & Hair Restoration will refund any payments made, less applicable co-pays and deductibles.

OPTION 2. I want the **D.** _____ listed above, but do not want my insurance billed. I understand I will be responsible for payment, furthermore considered a private pay patient. ***I understand I cannot appeal if my insurance is not billed.***

OPTION 3. I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment because there is no treatment being done.

This notice gives our opinion, not an official insurance decision. If you have other questions on this notice please call your insurance company directly.

Signing below means that you have received and understand this notice.

I. Signature:	J. Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11)
0566

Form Approved OMB No. 0938-



AUTHORIZATION FOR MEDICAL RECORDS RELEASE

I, _____, herein authorize: _____
PRINT PATIENT'S NAME PRINT DOCTOR OR FACILITY HOLDING RECORDS

Address: _____ City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____

To release and forward a COPY or SUMMARY of my medical records to:

Dr. Ricardo Mejia
Alli Rayner, PA-C
Ashley Syler, PA-C
2101 U.S. Highway One Jupiter, FL 33477
Phone 561-748-0510 | Fax 561-748-0598

I understand that the specific reports disclosed shall include:

(Note: If your records are to include AIDS/HIV status, Mental Health records, or Drug/Alcohol history, you must list them in space above.)

I understand that this consent is revocable upon written request to the practice, except to the extent that action by the practice has been taken in reliance on this authorization and that this authorization shall remain in force for a "reasonable" time in order to affect the purpose for which it is given.

Patient's Signature

Date

Witness

Date