JUPITER DERMATOLOGY & HAIR RESTORATION

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 smoke? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No
Are you latex intolerant? ☐Yes ☐No
Do you currently use/have used IV drugs? ☐Yes ☐No
Do you require antibiotics prior to surgery? ☐Yes ☐No
Do you bleed easily? ☐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: _____

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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:

□ Facial Fillers (Radiesse, Restylane, Perlane, Juvederm)
___Moderate to severe facial wrinkles and folds

□ Sculptra (Virtual face lift)
___ to improve facial volume
___ To improve sagging skin

□ Laser Hair Removal

□ Vein Therapy/ Sclerotherapy
___Eliminate spider and varicose veins

□ Skin Care
___ Chemical Peels
___ Microdermabrasion
___ Facials

□ CO2 Resurfacing Laser/ Ultra Pulse
___ Anti-aging skin resurfacing treatment

□ Botox or Dysport
___ Improve the appearance of wrinkles brow lines
___ Underarm sweating

□ IPL Photo Facial Rejuvenation
___To improve pigmentation and redness

□ BluLight
___ Pretreat cancer lesions

□ Hair Care/ Hair Loss/ Hair Transplant Surgery

□ 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:

JUPITER DERMATOLOGY & HAIR RESTORATION

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