JUPITER DERMATOLOGY & HAIR RESTORATION

Name: _____ Date of birth: ____/____/_____ Sex: _____
Street address: _____ City: _____
Zip code: _____ State: _____ Social Security#: _____-_____-_____
Daytime phone number: ( ) _____-_____ Cell phone number: ( ) _____-_____
Marital status (check one): ☐ Single ☐ Married ☐ Divorced ☐ Widow

How did you hear about our office? _____

E-Mail Address: _____

Emergency contact information

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

Employer information

Occupation: _____ Employer name: _____
Phone number: ( ) _____-_____ City, state: _____

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		Other cancers_____	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/screw	☐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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LASER & MED SPA
561.748.0510

Skin Care Questionnaire

1. Please check your skin type:

☐ Type I-	Very Fair/Blue Eyes/Freckles	Always Burn, Never Tan
☐ Type II-	Fair/ Blue, Hazel or Green Eyes	Always burn, Sometimes Tan
☐ Type III-	Cream White/Fair Skinned – Any Eye Color	Sometimes Burn, Always Tan
☐ Type IV-	Moderately Pigmented Olive or Light Brown Skin Tones (Hispanic, Asian, Indian, Middle Eastern, or Mediterranean)	Rarely Burn, Always Tan (Tan stays for months)
☐ Type V-	Darker Brown (Hispanic, Asian, Indian, Middle Eastern, or Mediterranean)	Very Rarely Burns; Tans Very Easily
☐ Type VI-	Darkest Brown/Black	Never Burns, Always Tan

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 or Vit C? ☐Yes ☐No Product Name:_____

6. <u>Are you interested in improving the appearance of your skin?</u> ☐ Yes ☐ No

☐Wrinkles & Fine Lines ☐ Sagging Skin/Volume Loss ☐Jowls ☐ Brown Spots ☐Tone & Texture ☐Pore Size

☐Redness/Broken Blood Vessels ☐Dryness ☐Acne ☐Pre-Cancerous Lesions ☐Removing Tattoos

7. Do you want to look ☐ Refreshed ☐ 5-10 years younger ☐ 10-15 years younger ☐ 20+years younger

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

9. Check which treatment you have had done previously:

☐Facials ☐Microdermabrasion/MicroNeedling ☐Chemical Peels ☐Laser ☐Kybella

☐Botox ☐Fillers (Sculptra, Radiesse, Restylane, Juvederm, Belotero) ☐None

10. What is your current makeup routine? _____

11. What type of foundation do you prefer (liquid, pressed) and what type of coverage (sheer/medium/full)?

_____

I am interested in obtaining more information on the following:

☐ **Facial Fillers** (Sculptra,Radiesse, Restylane, Belotero, Juvederm)
___Moderate to severe facial wrinkles and folds

☐ **Hand Rejuvenation** (restore lost volume due to aging)

☐ **Sculptra** ___ To improve facial volume
___ To improve sagging skin

☐ **CO_2/ReSurFX Laser**
__ Anti aging skin resurfacing treatment
__ Fractional/Fraxel Lasers

☐ **Botox or Dysport**
___Improve appearance of wrinkles and brow lines
___Fractional/Fraxel Laser

☐ **Laser Hair Removal**
☐ **Tattoo Removal**
☐ **Kybella** (Neck Fullness/Double Chin Treatment)
☐ **Vein Therapy/ Sclerotherapy**
___Eliminate spider and varicose veins.
___Treatment of Facial Veins/Broken Vessels
☐ **Skin Care**
___Chemical Peels ___ PRP
___Microdermabrasion/Microneedling
___Facials

☐ **IPL Photo-Facial/Skin Rejuvenation**
___To improve pigmentation/Redness/Stimulate Collagen

☐ **BluLight**
___ Pretreat cancer lesions

☐ **Hair Care/ Hair Transplant**
___Hair Loss/Thinning

☐ **Colorescience Mineral Makeup** (Chemical Free SPF)

☐ **Sunscreens** ____**Chemical Free** (Clear Zinc/Titanium Dioxide)
____**Sport/Water Resistant**

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Ricardo Mejia, MD
Ashley Syler, PA-C • Alli Rayner, PA-C

Consent NON-Face-to-Face "Virtual" Visits

Patient Name: _____ DOB: _____

I, _____ hereby voluntarily consent to receive "Virtual" care.

Examples of the virtual services offered here are:

Virtual Check-ins – You and your treating provider may have a brief phone call to obtain a prescription, or obtain results from a test to determine whether or not an in-person visit or other appropriate treatment is needed.

E-Visits – You may communicate with your treating provider through our patient portal or secure email.

Telehealth Visits – You and your treating provider can use real time interactive audio / video communication that permits real time communication – This type of visit is considered like an in-office visit. We will conduct a full Evaluation/Management visit to determine a treatment plan while you are home.

I understand that this consent form will be valid and remain in effect as long as I am receiving medical care/services at _____.

"Virtual Services" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of visit/care with which you are familiar, it is important you understand and agree to the following terms:

- **I understand that standard copay's, deductible and or coinsurance amounts will apply to these "Virtual Services/Visits" and will be billed to my insurance company.** _____(initials)
- Your treating provider will be at a different location from you. Additional medical assistants/ Medical personnel may also be present in the room with the Provider. _____ (initial)
- I understand that my voice and image may be recorded in order to assist in my treatment and I consent to any such audio and video recording. _____(initial)
- I understand there are potential risks to this technology, including but not limited to interruptions, unauthorized access, technical difficulties and call termination before all my concerns and questions are addressed or treated and it is my responsibility to make such condition or symptom known to the medical personnel as well as to make arrangements for follow up care. _____(initials)

This form has been explained to me and I fully understand this Consent for NON-Face to-Face "Virtual" Visit and agree to its contents.

Patient Signature: _____ Date: _____

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OFFICE POLICY & PATIENT RESPONSIBILITY REGARDING PAYMENTS

Your insurance coverage is a contract between you and your insurance company (not this office):

A. Cancellation/No Show Policy: If an appointment is not cancelled at least 24 hrs in advance you will be charged a $50 fee, and Mohs, if surgery is not cancelled at least 10 days in advance you will be charged a $75 fee, not be covered by your insurance.
B. Scheduled Appts; If a patient is 15 min past their scheduled appt time, we will try and accommodate you depending on the providers schedule, otherwise we will need to reschedule the appt.
C. Account Balance, we require that patients with balances over $50 on the acct are paid prior to receiving services as well as requesting to have medical records sent out.
D. Payment of your deductible is your responsibility (even Medicare has a deductible).
E. Co-payments are your responsibility and are due at the time of service.
F. Co-Insurance payments are your responsibility. Example: If your insurance company pays 80% of covered/discounted charges, you are responsible for 20% of covered/discounted charges. The 20% is called the co-insurance. If you have a secondary insurance. We will submit the 20% for reimbursement.
G. Filing insurance claims is a service provided by this office without charge, in no way relieves you of the responsibility of paying your bill. It is your responsibility to provide us with your current insurance information. It is your responsibility to confirm that your insurance coverage is in effect at the time of your visit and to respond to your insurance company's request for any add'l information needed from you to process the claim.
H. We will submit your cultures, biopsy's to the lab covered under your insurance plan. Lab charges are separate charges and have nothing to do with our office. Any outstanding lab fees will need to be handled by you and the lab facility.
I. In cases of divorce or separated parents, our policy is that the parent accompanying the child to the office visit is responsible for full payment of all fees.

I'm in agreement with the office policy and patient responsibility set forth above.

Patients Name: _____

Signature of Patient/Legal Guardian_____

Date: _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Jupiter Dermatology & Hair Restoration to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent.

With this consent, Jupiter Dermatology & Hair Restoration may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Jupiter Dermatology & Hair Restoration may mail to my home or other alternative locations any Jupiter Dermatology items that assist the practice in carrying out TPO, such as appointment reminders cards, notices, patient statements as long as they are marked Personal and Confidential. I have the right to request that Jupiter Dermatology restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

_____**By signing this form, I am consenting to Jupiter Dermatology & Hair Restoration use and disclosures of my PHI to carry out TPO.**

_____**I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Jupiter Dermatology may decline to provide treatment to me.**

I acknowledge reading the privacy practice notice above and sign below to accept.

Name of Patient: _____

Signature of Patient/Legal Guardian: _____

Date: _____