JUPITER DERMATOLOGY & HAIR RESTORATION

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

New Patient Information Form

Patient Name: _____ **DOB:** _____

Sex: ☐ Male ☐ Female ☐ Non-binary **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Other

Primary Address: _____ **City:** _____

Zip Code: _____ **State:** _____ **E-mail Address:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

How did you hear about our practice? _____

Employer: _____ **Occupation:** _____ **Phone Number:** _____

Emergency Contact: _____ **Phone Number:** _____

Primary Care Physician: _____ **Phone Number:** _____

Preferred Pharmacy: _____ **Phone Number:** _____

Our office may contact you via phone, text, email or leave voicemail. If any, please name method of communication you do NOT want us to contact you by?_____

Do you authorize our office to discuss your medical information with family members or other individuals? ☐ Yes ☐ No If yes, please provide names and phone numbers below:
Name_____**Phone**_____

NOTICE OF PATIENT PRIVACY PRACTICES CONSENT

I have been given the opportunity to read a copy of Jupiter Dermatology & Hair Restoration's NOTICE OF PATIENT PRIVACY PRACTICES. I hereby give my consent to Jupiter Dermatology & Hair Restoration to use and disclose my protected health information (PHI) to carry out treatment, obtain payment and other necessary healthcare operations.

Appointment Policy

If you are 15 minutes past your scheduled appointment time, we will do our best to accommodate you, but we cannot guarantee that you will be seen. This is dependent on the providers' schedule, if unable to accommodate, we will reschedule your appointment.

Cancellation Policy

If cancellation is necessary, we require that you call at least 24 hours in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time. If an appointment is not cancelled at least 24 hours in advance, you will be charged a $50 fee that is not covered by your insurance plan.

Patient Signature_____**Date**_____

Parent or Legal Guardian Signature_____**Date**_____

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CONSENT FOR TREAMENT

I voluntarily give my consent for treatment and also my consent to any procedures the professional medical care providers perform in the dermatology office and deem necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridement of wounds, injection of skin lesions, cauterization of skin lesions. Our providers will discuss in detail any procedure they plan to perform, answer all questions relating to the procedure and obtain oral and signed informed consent in the exam room prior to proceeding with services.

Patient Signature_____**Date**_____

Parent or Legal Guardian Signature_____**Date**_____

TELEHEALTH (VIRTUAL SERVICES) CONSENT

Telehealth/virtual services mean that you may be evaluated and treated by a healthcare provider or specialist from a distant location via electronic communication. This may include follow up visits for lab results. Since this may be different than the visit/care you are familiar with, it is important that you understand and agree to the following terms:

- Your visit will be billed to your insurance company, but you will subject to your Telehealth Benefits. This means you may be responsible for copayments, deductibles, and co-insurance amounts; it depends on your policy's benefits.
- Your treating provider will be at a different location from you. Additional medical assistants and other professional personnel may also be present in the room with the provider.

I fully understand the above and consent for Telehealth/Virtual Visits

Patient Signature_____**Date**_____

Parent or Legal Guardian Signature_____**Date**_____

Financial policy

I, the undersigned, understand that Jupiter Dermatology & Hair Restoration has agreed to accept Medicare and/or health insurance for payment of my bills by my signature below. I acknowledge and understand that I am fully responsible for any copayment, deductible and/or coinsurance amounts at the time of service. I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or are pre-existing, that I am responsible to pay the balance in full promptly.

Patient Signature_____**Date**_____

Parent or Legal Guardian Signature_____**Date**_____

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Medical History

Circle any conditions that apply:

Arthritis	Glaucoma	Thyroid	Melanoma	HIV/AIDS (Exposure)
Chronic cough	Asthma/Bronchitis	Chest Pain	Heart Disease	Hepatitis A/B/C
Lymphoma	Squamous Cell	Basal Cell	Diabetes	Emphysema
Hypertension	Mitral Valve Prolapse	Cancer (specify what kind):_____		

Do you have any family history of skin cancer? ☐ Yes ☐ No If so, what kind:_____
Please list any medical conditions we should be aware of: _____
Please list all medications you are currently taking: _____
_____
Please list any known allergies: _____
Reason for today's visit: _____

Do you smoke? ☐ Yes ☐ No
Do you drink beer, wine or liquor? ☐ Yes ☐ No
Are you currently pregnant? ☐ Yes ☐ No
Do you use/have used IV drugs? ☐ Yes ☐ No
Have you received the Flu Vaccine? ☐ Yes ☐ No
Do you have an Advanced Directive? ☐ Yes ☐
Are you allergic to latex? ☐ Yes ☐ No
Do you bleed easily? ☐ Yes ☐ No
Do you have a "Do Not Resuscitate (DNR)" order? ☐ Yes ☐ No
Do your eyes ever feel uncomfortable? ☐ Yes ☐ No
Have you received the pneumococcal vaccine? ☐ Yes ☐ No
Do you require antibiotics before surgery? ☐ Yes ☐ No
Do you have artificial joints/screws? ☐ Yes ☐ No
Have you ever had dental anesthesia (Novocain) ? ☐ Yes ☐ No Any adverse reaction?:_____

Skin Care Questionnaire

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

I am interested in obtaining more information on the following:

☐ **Facials fillers** (Contour, Sculptra, Defyne, Restylane, Juvederm, Voluma)
___ Moderate to severe facial wrinkles and folds

☐ **CO2/Resurfx Laser/PiQo4**
___ Anti-aging skin resurfacing treatment
___ Fractional/Fraxel Lasers

☐ **Botox or Dysport**
____Improve the appearance of wrinkles and brow lines
____Treatment of TMJ/clenching or grinding

☐ **IPL Photo-Facial/Skin Rejuvenation**
___ To improve pigmentation/Redness/stimulate collagen

☐ **Hand Rejuvenation**
__ Restore volume due to aging

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

☐ **Laser Hair Removal** ☐ **Tattoo Removal** ☐ **Kybella** (Neck fullness/Double chin treatment)
☐ **Vein Therapy/Sclerotherapy** ☐ **Blu Light** (Prevent cancer lesions)
☐ **Hair care : Hair loss/Thinning/Transplant**
☐ **Sunscreens** (Chemical Free/Sport & Water resistant)

Are you interested in having facial treatments? ☐ Yes ☐ No

Check which treatments you have had done previously:
☐ Facials ☐ Microdermabrasion/Microneedling ☐ Chemical Peels ☐ None

I grant my permission for the doctors and staff of Jupiter Dermatology & Hair Restoration (JDHR) to treat me, including any biopsy or procedure(s) as deemed necessary in the exercise of their professional judgment.

PLEASE INITIAL:

☐ I understand that medical care requires my cooperation, and I will 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 physician 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 will be used for the purpose of medical/scientific study and research, education, before and after surgical portfolios and/or documentation for my medical record. I understand that photographs and recorded material may include appropriate portions of the body to demonstrate surgery/procedures and that every effort will be made to protects the patient's identity in those materials. I further acknowledge that all recorded media obtained is that the sole property of JDHR. I hereby certify that I have read the forgoing CONSENT and fully understand the contents thereof.

☐ I have read and understand the medical consent forms that have been provided to me by the doctors and staff of JDHR. I authorize my doctor to release any information, including the diagnosis and the records of any treatment or examination rendered to myself, or my dependent 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 or my dependents. I understand that if not covered under my insurance policy, I may be billed by an outside laboratory for work that is performed in this office.

Written Acknowledgement Form
Receipt of Notice of Privacy Practices

Patients Right of Disclosures: In general, the HIPAA privacy rules give individuals the right to request restriction on uses and disclosures and health information. The individual is also provided the right to request confidential communications of health information be delivered by alternative means.

I authorize JDHR to contact me in the following manner:

- Detailed message at: HOME CELL WORK (circle one)
- Leave Message with call back number only: HOME CELL WORK (circle one)
- Mail to home : YES_____ NO_____ (select one)
- Email: YES_____(enter email) NO_____ (select one)

List all persons in your household who, in your absence, may make requests on your behalf, and with whom we may speak regarding your medical records:

_____

I acknowledge that I have read this form and agree to my outlined choices:

Signature of Patient_____
Date_____