Clearlyderm Dermatology

Get Serious About Your Skin®

PATIENT INFORMATION

First Name _____ Last Name _____ Middle _____

Address _____ Apt _____ City _____ State ____ Zip _____

Email Address _____ Date of Birth _____/____/____

Cell (_____) _____ Home (_____) _____

Birth Gender __ M __ F Preferred Gender __ M __ F ☐ Other _____

Marital Status __ S __ M __ W __ D Spouse/Partner Name _____ Phone (_____) _____

Primary Physician _____ Office Number (_____) _____

Pharmacy _____ Ph (_____) _____

City _____ Intersection _____

Emergency Contact _____ Relationship _____ Phone (_____) _____

Occupation _____

INSURANCE INFORMATION:

PRIMARY Insurance Policy _____ Policy ID# _____

Social Security Number # _____

Policy Holder's Information (if different than patient)

First Name _____ Last Name _____ Middle ____

SSN _____ Sex __ M __ F Date of Birth _____/____/____

SECONDARY Insurance Policy _____ Policy ID# _____

Policy Holder's Information (if different than patient)

First Name _____ Last Name _____ Middle ____

Last 4 of SSN _____ Sex __ M __ F Date of Birth _____/____/____

HOW DID YOU HEAR ABOUT US:

☐ Google ☐ Facebook/Social Media ☐ Yelp ☐ Other Online ☐ Friend or Family ☐ Saw Your Sign ☐ Insurance Directory

☐ Other _____

I AM INTERESTED IN ADDITIONAL INFORMATION ON:

☐ Injectables (e.g. Botox, Dysport, Facial Fillers)
☐ Laser Treatments (Resurfacing, Brown and Red Spots)
☐ Laser Hair Removal
☐ Vein treatments
☐ Aesthetic treatments (Facials, Peels, Microneedling, Microdermabrasion)
☐ Hydrafacial
☐ PRP

RECORD RELEASE & ASSIGNMENT OF BENEFITS:

I hereby authorize ClearlyDerm LLC to release pertinent information regarding my care to other physicians involved in my case and/or insurance companies holding policies on me. I authorize my insurance company to directly remit payment to ClearlyDerm LLC for medical or surgical services provided and billed.

X _____ X _____ X _____

Print Patient Name Signature Date

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COMMUNICATION CONSENT:

AUTHORIZATION TO DISCUSS/RELEASE MEDICAL INFORMATION & BIOPSY RESULTS

I ☐ AUTHORIZE, ☐ DO NOT AUTHORIZE, Clearlyderm, LLC. to communicate my medical information via telephone to myself and/or the following optional person below:

NAME _____ RELATIONSHIP _____ Phone ( )_____

PRIMARY/REFERRING PHYSICIAN _____

I ☐ AUTHORIZE, ☐ DO NOT AUTHORIZE, Clearlyderm to leave medical information on my voicemail at this designated telephone number: Home: ( )_____ Cell: ( )_____

I ☐ AUTHORIZE, ☐ DO NOT AUTHORIZE, Clearlyderm to send medical information to my email at the designated Email address: _____

X _____ X _____ X _____

Print Patient Name | Signature | Date

CONSENT TO TREAT A MINOR: MUST COMPLETE IF PATIENT UNDER 18

A PARENT OR GUARDIAN MUST ACCOMPANY A MINOR TO THE INITIAL VISIT
MINOR CONSENT: THIS SHOULD BE SIGNED IF THE MINOR WILL NOT BE WITH A PARENT, ON FUTURE VISITS.

I give the doctors and staff at ClearlyDerm permission to treat _____ in my absence.
Patient Name

X _____ X _____ X _____

Parent/Guardian Name | Signature | Date

Additional Parent/Guardian Name _____ Phone ( ) _____

HIPAA PRIVACY PATIENT CONSENT FORM:

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. You have the right to revoke this consent , in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance of your prior Consent. The Practice proved this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations;
- The Practice has a Notice of Practices and that the patient has the opportunity to review this Notice;
- The Practice reserves the right to change the Notice of Privacy Practices;
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions;
- The patient may revoke this consent in writing at any time and all future disclosures will then cease;
- The Practice may condition treatment upon the execution of this Consent.

X _____ X _____

Signature | Date

This Consent was signed by (Printed Name - Patient or Representative) _____

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MEDICATIONS: (PLEASE ENTER ALL CURRENT MEDICATIONS)

Please Include Vitamins and Over the Counter Medications

Name _____ Dose _____ Frequency _____
Name _____ Dose _____ Frequency _____
Name _____ Dose _____ Frequency _____
Name _____ Dose _____ Frequency _____
Name _____ Dose _____ Frequency _____
Name _____ Dose _____ Frequency _____
Name _____ Dose _____ Frequency _____

Any additional medications please note on back of form

ALLERGIES: (PLEASE ENTER ALL ALLERGIES TO MEDICATIONS)

CAUTIONS: (PLEASE CHECK ALL THAT APPLY)

Have you had an artificial joint replacement? ☐ Yes ☐ No
what location(s) _____
Do you have an: ☐ artificial heart valve ☐ pacemaker ☐ defibrillator
Are you allergic to: ☐ lidocaine ☐ adhesives ☐ topical antibiotic ointment
Are you taking blood thinners or Aspirin? ☐ Yes ☐ No
Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No
Do you require antibiotics prior to a surgical procedure? ☐ Yes ☐ No
Do you get GI issues or yeast infections with antibiotics? ☐ Yes ☐ No
Do you currently smoke tobacco? ☐ Yes ☐ No
Have you ever smoked tobacco in the past? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No

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PAST MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Other _____
- ☐ **None**
- ☐ Depression
- ☐ Diabetes
- ☐ Renal Disease
- ☐ Hepatitis Type A, B, or C
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Inflammatory Bowel Disease

PAST SURGICAL HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy ☐ Left ☐ Right
- ☐ Lumpectomy ☐ Left ☐ Right
- ☐ Breast Implants
- ☐ Gallbladder Removed
- ☐ Other _____
- ☐ **None**
- ☐ Coronary Artery Bypass
- ☐ Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement
  - ☐ Knee ☐ Hip ☐ Right ☐ Left
- ☐ Kidney Removed
- ☐ Kidney Transplant
- ☐ Ovaries Removed Due To:
  - ☐ Endometriosis ☐ Cancer ☐ Cyst
- ☐ Prostate Removed
- ☐ Spleen Removed
- ☐ Hysterectomy Due To:
  - ☐ Fibroids ☐ Cervical Cancer ☐ Uterine Cancer
- ☐ Tuballigation

SKIN DISEASE HISTORY: (PLEASE CHECK ALL THAT APPLY)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
  - Location _____ Year ____
- ☐ Blistering Sunburns
- ☐ Other _____
- ☐ **None**
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
  - Location _____ Year ____
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
  - Location _____ Year ____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF _____?

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of skin cancer ☐ Yes ☐ No Type: ☐ Melanoma ☐ Basal/Squamous Cell ☐ Unsure

If Melanoma, which relative(s)? _____

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FINANCIAL POLICY:

- Payment is due at the time of service, including copayments and deductibles.
- All charges will become the patient's financial responsibility if the insurance carrier has not paid within 60 days.
- All cosmetic procedures are to be paid for at the time of service. We do not bill these procedures to insurance companies.
- I understand if blood work, biopsies, or other cultures are done, I may receive a separate invoice from the laboratory or the pathology doctor. I will be responsible for paying all such invoices directly to the lab or the physician.
- I understand that for any aesthetic appointment with a medical aesthetician there will be a $40 charge if the patient does not show up or cancels within less than 24 hours of the appointment.
- I understand that for any cosmetic or surgical appointment scheduled for 30 minutes or longer, there will be a $100 charge if the patient does not show up or cancels within less than 24 hours of the appointment.
- I understand that for any Mohs surgical appointments, there will be a charge of $100 if a patient does not show up or cancels within less than 48 hours (2 business days) of the appointment.
- I understand that all Laser Resurfacing appointments with Dr. Nicole Conrad require a 50% deposit of the total treatment. This deposit will be collected at the time of scheduling. I understand I will forfeit the deposit if I no-show or cancel within less than 72 hours (3 business days) of the appointment.
- For all other standard medical and cosmetic appointments, please give us at least 24 hours notice (1 business day). If you do not cancel or reschedule your appointment with at least 24 hours notice, Clearlyderm will require a hold on your credit card of $50 to book your next appointment. If you show up to your next appointment, your credit card will not be charged. If you do not show up or cancel within less than 24 hours for this next appointment, Clearlyderm will charge the $50 hold. This "no-show charge" is not reimbursable by your insurance company.
- After three consecutive no-shows to your appointment, we may request that you seek care at another Dermatology practice.
- Clearlyderm sends text messages and phone call reminders the week of your appointment. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment.
- I authorize Clearlyderm and its service providers to store my credit card number and details to facilitate future credit-on-file transaction debits and correction credits for which I shall be notified of in advance prior to these transactions.

I have read and fully understand Clearlyderm LLC's financial policy. I give Clearlyderm LLC and its healthcare providers authorization to perform medical and cosmetic treatments, therapy and administer necessary medication, including but not limited to: biopsies, cryotherapy, ED&C, and laser treatments.

****THIS SHOULD BE SIGNED BY THE PERSON RESPONSIBLE FOR PAYMENT.****

Signature: _____ Printed Name: _____

Relationship: _____ Date: _____