ASPIRE® DERMATOLOGY

COSMETIC PATIENT INFORMATION

Please Complete All Sections on All Pages

CELL PHONE # _____ ☐ Preferred ☐ Alternate

HOME PHONE # _____ ☐ Preferred ☐ Alternate

PATIENT'S NAME (Last, First, MI)_____**SEX**_____**BIRTH DATE**____/____/____

PRIMARY ADDRESS (STREET)_____**APT#**_____

CITY _____ **STATE** _____ **ZIP**_____

ALTERNATE ADDRESS (STREET)_____**APT#**_____

CITY _____ **STATE** _____ **ZIP**_____

EMAIL ADDRESS_____

Would you like to receive emails from Aspire Dermatology for patient, practice, promotions and products information? *Yes* ☐ *No* ☐

HOW DID YOU HEAR ABOUT ASPIRE DERMATOLOGY? _____

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SKIN TYPE?

- ☐ **Very Oily Skin, large pores**
- ☐ **Oily Skin**
- ☐ **Dry Skin**
- ☐ **Sensitive Skin**
- ☐ **Combination Skin (Oily T-Zone, dry to normal cheeks)**

WHAT ARE YOUR AREAS OF CONCERN?

- ☐ **Frown lines between eyebrows**
- ☐ **Crease lines around nose & mouth**
- ☐ **Wrinkles around eyes/crow's feet**
- ☐ **Forehead lines/creases**
- ☐ **Skin Resurfacing**
- ☐ **Acne**
- ☐ **Freckles/Sun Spots**
- ☐ **Hyperpigmentation**
- ☐ **Facial Hair/Unwanted Hair**
- ☐ **Sagging Skin**
- ☐ **Double Chin**
- ☐ **Scars**
- ☐ **Vascular Lesions**
- ☐ **Other**_____

_____

_____

PHOTOGRAPH DISCLOSURE: When it is appropriate and necessary, Aspire Dermatology staff and Providers may take clinical photographs during cosmetic consultations, pre and post treatments. These photographs are used to aid in tracking outcomes and professional education. Clinical photographs are considered a routine practice of the care and treatment of our patients and are covered within the general admission and consent to treat.

PLEASE LIST THE INDIVIDUALS WITH WHOM WE ARE AUTHORIZED TO DISCUSS YOUR INFORMATION

I hereby authorize Aspire Dermatology to communicate information regarding my procedure/results of my procedure/billing to/with:

Name_____ **Relationship**_____ **Phone:** _____

Name_____ **Relationship**_____ **Phone:** _____

OR

☐ **Do not disclose any information regarding appointments, procedures, results, or billing to anyone other than myself**

Certification of patient information

I have reviewed my patient demographic on this date and verify that all information reported to Aspire Dermatology is correct.
I hereby acknowledge that a copy of the Notice of Privacy Practices for Aspire Dermatology has been made available to me. I have the right to obtain a paper copy upon request.

SIGNATURE:_____**DATE:**_____

PLEASE TURN THE PAGE OVER

ASPIRE® DERMATOLOGY

PATIENT NAME:_____ **DATE OF BIRTH:**_____/_____/_____

PAST MEDICAL HISTORY: (Please check all that apply)

- Currently Pregnant or Planning a Pregnancy
- Stroke
- Breastfeeding
- Bell's Palsy
- Immunosuppression: chemo/ radiation
- Multiple Sclerosis (MS)
- History of Severe Allergies
- Chronic Prednisone Use
- History of Anaphylaxis
- Heart Arrhythmias (slow/fast/irregular heartbeats)
- History of Accutane Use; if yes, completion date: _____
- HIV/AIDS
- Cardiovascular Disease
- Heart Attack
- History of Cold Sores
- Blood Thinners
- Allergy to Cow's Milk Protein
- Bleeding Disorder
- History of Poor Wound Healing
- Seizures
- History of hospitalization due to result of allergic reaction
- Neuromuscular Disorders or Muscle Weakness (ALS, Lou Gehrig's, Myasthenia Gravis or Lambert-Eaton Syndrome)
- Have had breathing problems (asthma or emphysema)
- Difficulty Swallowing
- History of Facial Surgery or Facial Implants
- Diabetes
- Tattoo or Permanent Makeup
- Keloid Scarring
- Breast Cancer: History of Radical Mastectomy
- History of Melanoma
- PCOS
- DLE/SLE

PREVIOUS COSMETIC PROCEDURES: (Please check all that apply)

- Botox
- Fillers (Juvederm/Radiesse/Restylane/Voluma)
- Kybella
- Microdermabrasion
- Chemical Peels
- Facials
- Extractions
- Tattoo Removal
- Laser Hair Removal
- Skin Resurfacing/Rejuvenation
- Skin Tightening

WHAT IS YOUR DAILY SKIN CARE REGIMEN? _____

_____

_____

_____

_____

DATE OF LAST SUN EXPOSURE? _____

PLEASE TURN THE PAGE OVER

PATIENT NAME:_____ **DATE OF BIRTH:**_____/_____/_____

PHARMACY INFORMATION - Should Aspire Dermatology need to prescribe medication(s)

Pharmacy Name:_____ Pharmacy Phone Number: _____

Pharmacy Address: _____

I would like for my current medications prescribed to me by other service providers to be downloaded electronically from the Surescripts database. **YES** ☐ **NO** ☐

MEDICATIONS/SUPPLEMENTS (Please List)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you currently being treated with class III anti-arrhythmic or Potassium channel blocker drugs for cardiac disorders?
(Such as: Pacerone, Amiodarone, Tikosyn, Defetilde, Sotalol Hydrochloride, Multaq, Dronedarone, Cordarone, Betapace, Corvert, Ibutilide, Nexterone, Sorine or Sotylize) ☐ **YES** ☐ **NO**

ALLERGIES (Please list drug allergies, and types of adverse reactions)

_____ _____

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

Smoking Status: please check which option applies:

- ☐ Current every day smoker;
- ☐ Current someday smoker;
- ☐ Former smoker;
- ☐ Smoker, current status unknown;
- ☐ Never smoker;
- ☐ Unknown if ever smoked;

Alcohol use

- ☐ Alcohol - none
- ☐ Alcohol - less than 1 drink per day
- ☐ Alcohol - 1-2 drinks per day
- ☐ Alcohol - 3 or more drinks per day

At Aspire Dermatology, we make every effort to provide our patients with timely care in the communities where they live and work. Your provider of care may not always be the same, however, Aspire Dermatology is comprised of a highly professional, skilled and knowledgeable team of: Physicians, Nurse Practitioners, Physician Assistants and Aestheticians, who are ready and available to serve all your skin care needs with the utmost professionalism, respect and care.

I certify that all the information provided on this date to Aspire Dermatology is correct.

SIGNATURE:_____ **DATE:**_____

Financial Agreement:

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: In the event that my insurance will pay all or part of the physician's charges, the physician who renders service to me is authorized to submit a claim for payment to my insurance carrier. The physician's office is not obligated to do so, unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim, and if pertinent insurance coverage information is presented at, or prior to the time of the appointment. I hereby assign benefits to be paid on my behalf to Aspire Dermatology. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balance due after insurance payments in accordance with the policy for payment for such bills of Aspire Dermatology for charges not paid for within a reasonable period of time by insurance or third-party payer. I certify that the information given with regard to insurance coverage is correct. I authorize Aspire Dermatology to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

Co-pays, deductible portions, and co-insurance: Aspire Dermatology will expect **payment of co-pays, deductible portions, and co-insurance at the time of service**. A $5.00 administrative charge will be assessed when patients request to delay co-pay, deductibles and co-insurance payment. **Patients with an outstanding balance older than 90 days will have a past due charge of $25.00 applied, must make arrangements for payment prior to scheduling appointments, and in the absence of a payment plan, the account will be turned over to a collections agency.** Aspire Dermatology accepts all major credit cards as a form of payment for your convenience. We realize that patients have financial difficulty and our financial counselors will work with you to ensure you receive needed medical care. Please note that Aspire Dermatology and its providers are considered "specialists" and co-pays are generally higher than the co-pays paid to Primary Care Physician.

Non-sufficient Funds Charge: Aspire Dermatology will charge a **$30** NSF fee in the event of a returned or bad check for any and all reasons. The patient will have to make arrangements for all future visits to be paid for either by cash or credit card; a check will no longer be accepted. Please note that as the depositor of the check, Aspire Dermatology gets charged a fee by our financial institution in the event of a returned check.

Missed Visits: Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. A **$25.00** missed appointment charge will be added to your account if you do not provide us with the requested 24-hour cancelation or rescheduling notice. A **$75.00** missed appointment fee will be added to your account for missed or rescheduled Mohs surgery and Excision appointments under the 24-hour notice. A **$50** missed cosmetic appointment fee will be added to your account if you do not provide us with the requested 24-hour cancellation or rescheduling notice.

HMO Insurance Plans: For purposes of claim processing, Aspire Dermatology needs referring information from the patient such as referring physician's name, address and phone number, and the referral form. Without the information, the claim will not process and the bill will be the responsibility of the patient. *If you have an HMO coverage*, you are **required** to get a referral prior to your visit at Aspire Dermatology. If a referral is not obtained prior to the visit, any financial obligations will be billed to the patient.

Insurance Eligibility & Benefits Verification: Aspire Dermatology is dedicated to assisting our patients with precise benefits coverage, by making efforts to verify eligibility and benefits for each patient's insurance policy for any financial obligation, if any, resulting from that date of service; however, we will not be liable for any inaccurate information provided to us wherever the information is available. Policies and coverage determinations may vary from payor to payor, plan to plan, and year to year, even if member ID's and ID cards stay the same. Also, not all services are covered in all insurance plans. Please contact the member services department of your insurance company with additional questions regarding your policy and coverage.

SELF PAY PATIENTS: Please be advised if you have no insurance coverage, you are expected to pay for the "Office Visit" and treatment at the time of your visit. There could be additional fees for treatment performed the day of your visit. Those fees are expected to be paid the same day, or may be invoiced after charges for services rendered are determined. If there is any lab work or biopsies done during your visit, you will receive a bill from the processing Laboratory. This bill does not come from us. This is an outside bill.

COSMETIC PATIENTS: Aspire Dermatology will expect **payment of consultation fees and treatment costs at the time of service**. Consultation fees are due at the time of the consult and are not refundable, but will be credited towards your treatment cost in the event that treatment is completed. Consultation fees, product and treatment costs are subject to change without notice.

The undersigned certifies that they have read and understand the foregoing and fully accepts all terms specified above.

_____	_____
Signature of Patient or Responsible Party	**Print Name**
_____	_____
Relationship to Patient	**Date Signed**