Jason Green, DO, FAOCD, FAAD

PATIENT INFORMATION

Date:_____ Referred By:_____

Patient Name:_____

Circle One: Male or Female Married Single Divorced Widowed

Address:_____

Phone Number:_____ Mobile Number:_____ Check Preferred

Date of Birth:_____ Email:_____

Primary Care Physician:_____ Phone # _____

If Minor, name of parent or guardian:_____

Emergency Contact Name:_____Relationship_____

Phone Number:_____

MEDICAL INFORMATION RELEASE (HIPAA RELEASE)

I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:
( ) Spouse / Name & phone number_____

( ) Child(ren) Name/phone number _____

( ) Other name/relationship/phone number_____
This release will remain in effect until terminated by me in writing.

MESSAGES

Please call:_____

( ) You may leave a detailed message

( ) Do not leave a detailed message, please leave a message asking me to return your call

Signature:_____

Witness:_____

Date:_____

NOTICE OF PRIVACY POLICIES/ACKNOWLEDGEMENT OF RECEIPT

Date:_____

I Acknowledge I was provided with a copy of Green Dermatology & Cosmetic Center's Notice of Privacy Policies.

Name: _____Signature_____

If completed by a personal representative, please print and sign your name in the space below:

Name: _____Signature_____

Relationship to patient: _____

I have made a good faith effort to obtain a written acknowledgement of receipt of Green Dermatology & Cosmetic Center's Notice of Privacy policies but was unable for the following reason:

_____Patient refused to sign _____Patient is unable to sign

Employee name/Signature_____Date_____

Insurance Information

Insurance Company: _____ID #_____

Subscriber Name: _____Date of birth_____

Disclosure Statement

As a courtesy to you, we will file your charges to your insurance company for services our medical providers rendered today. Once payment is received, we will adjust certain balances according to our contracts with your insurance carrier. If we do not have a contract with your insurance carrier, you will be responsible for payment at the time of service.

I have spoken with an employee of Green Dermatology & Cosmetic Center and I understand fully that I am responsible for all amounts not covered by insurance. I also understand that in the event my insurance carrier does not pay, I am responsible for all additional charges incurred by Green Dermatology & Cosmetic Center or its agent to collect any debt.

Patient Signature: _____Date_____

Green Dermatology & Cosmetic Center Intake and History Form

Patient Name: _____

Preferred Pharmacy: _____ Phone Number: _____

City or Zip Code: _____

Medical History:

Please select any of the following medical conditions you have:

___Anxiety ___ Arthritis ___Asthma ____ Atrial Fibrillation ___Bone Marrow Transplant ___ BPH ___Breast Cancer

___Colon Cancer ___ COPD ___Coronary Artery Disease ___Depression ___Diabetes ___End Stage Renal Disease

___GERD ____Hay Fever ___Hearing Loss ___Hepatitis ___Hypertension ___HIV/AIDS ___Hypercholesterolemia

__Hyperthyroidism ___Leukemia ___Lung Cancer ___Lymphoma ___Prostate Cancer ___Radiation Therapy

___Seizures ___Stroke ___ NONE Other: _____

Past Surgical History:

___ Appendix ___Bladder ___Breast Biopsy ___Breast Lumpectomy ___Mastectomy (right, left or bilateral)

____ Colon, specify_____ ___Gall Bladder ____Heart, specify _____

___ Joint replacement, specify _____ Kidney, specify _____

___ Liver, specify _____ ____Ovaries, specify _____

____Prostate, specify _____ Rectum, specify _____

_____ Spleen ___Testicles, specify _____ _____Uterus, specify_____

_____None Other:_____

Skin Disease History:

___Acne ____Actinic Keratoses ____Basal Cell Skin Cancer _____Squamous Cell Skin Cancer ____Melanoma

___Blistering Sunburns ___Dry Skin ___Eczema ___Flaking or Itchy Scalp ____Poison Ivy ___Precancerous Moles

___ Psoriasis ___None Other: _____

Do you wear Sunscreen? Yes No SPF? _____ Do you tan in a tanning bed? _____

How often do you exercise? _____ Caffeine Intake? _____

Do you have a Family History of Melanoma? Yes No If yes, which relative? _____

Medications: _____

_____

_____

Allergies: _____

_____

Smoking Status: Circle One: Current Smoker Former Smoker Never Smoker

Packs per day? _____ Total Years Smoking? _____

Driving Status: _____ Drives during the day _____ Drives at night

Signature:_____

Green Dermatology & Cosmetic Center

Financial Policy

We are committed to providing quality care to all of our patients. The following is a statement of our financial policy.

All Copayments, co-insurance and deductibles are due at the time of your visit. We accept Cash, Checks, Visa, Mastercard, American Express and Discover.

Insurance: As a courtesy, we will bill your insurance company for your visit and services. It is your responsibility to be familiar with your insurance terms, contract and coverage. It is the patient's responsibility to understand Deductibles, copayment, co-insurance and what is covered what is not covered.

HMO/Referrals: It is the patient's responsibility to obtain referrals from the primary care physician if required for your visit. If you receive treatment without proper referral or authorization, that is ultimately not covered, you will be responsible for all the services rendered.

Collections: Payment is due at the time services are rendered. Should your account become a collections problem, the patient assumes all costs of collection. The collection agency charges a fee of 30% of the balance. If your account goes into collections, you cannot be seen at our office until that balance is cleared with the collection agency.

Non-Covered Services: Cosmetic services are not covered by insurance and payment is due at the time of service. Some medical treatments are not covered by insurance; it is the patient's responsibility to know whether the services are covered or not. Cosmetic consultations are $150. This fee can be applied toward any cosmetic service provided.

Products/Services: There are no guaranteed in medicine. There is not guarantee written or implied that a product or service will satisfy all your needs. There are ***ABSOLUTELY NO REFUNDS*** for products or services rendered.

Cancellations/No Shows: Dr Green takes the time necessary to treat his patients as he would want to be treated. We DO NOT over-book, your appointment time is reserved for you. Taking care of patients properly take time. Therefore, a "NO SHOW" fee of **$50** will be charged if an appointment is not cancelled or rescheduled 24 hours in advance. Surgery "NO SHOW" fee is **$100.**

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY. I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITIONS SEST FORTH ABOVE.

Patient/Responsible Party Name_____

Signature_____ Date: _____

Patient Authorization and Consent Form for Treatment during COVID

On March 11, 2020, the World Health Organization declared the COVID-19 disease a pandemic. As a result many hospitals and surgery centers put a hold on all elective and non-urgent procedures and surgeries. This was a part of an effort to save personal protective equipment (PPE) for frontline healthcare workers treating COVID-19 patients.

In many areas of the country, there is enough PPE, and elective/non-urgent procedures and surgeries are resuming. However, there is still a risk for performing these procedures and surgeries during the COVID-19 pandemic. These risks include but are not limited to exposure to other patients, healthcare staff and healthcare facilities.

More Facts

I understand that COVID-19 is very contagious. It is most likely spread by person-to-person contact. I understand that my doctor and his or her staff will follow all laws and recommendations from local, state, and national health officials. However, there are still risks of being infected with COVID-19 during a procedure or surgery. I agree to assume the risks, and I give permission for my doctor and the staff to perform a procedure, regular appointment, or surgery on me.

Some patients have a higher risk of complications from COVID-19, including those with:

- Asthma
- Chronic lung disease
- Serious heart disease or problems
- Chronic kidney disease
- Extreme obesity
- A compromised or suppressed immune system
- Liver disease
- Pregnant
- Age 65 or older
- Nursing home or long-term care facility residents

Some risks are not yet known. I understand that if I have one or more of these conditions, I may have a higher chance of getting COVID-19 and health problems if I get COVID-19. I understand that these problems may be serious. I may have to be in the hospital for a long time and could even die.

I understand that possible exposure to COVID-19 before, during, or after my procedure or surgery may result in: a COVID-19 diagnosis, a long quarantine or self-isolation, more tests, being in the hospital, intensive care treatment, intubation/ventilator support, short-term or long-term intubation, other complications, and the risk of death. Also, after my office visit, elective procedure or surgery, I may need to go to an emergency room or hospital for care. I have been given the option to wait until a later date to have my visit, procedure, or surgery.

I understand all of the risks, including but not limited to the potential problems related to COVID-19, and I would like to proceed with my visit, procedure, or surgery.

Consent to Treatment

DO NOT SIGN THIS FORM UNTIL YOUR QUESITONS HAVE BEEN ANSWERED.

I understand the facts provided to me on this page. I give my consent for an office visit, elective procedure or surgery. By signing below, I agree that staff/doctor has discussed the facts in this form with me, that no one has given me any guarantee, that I have had a chance to ask questions and that all of my questions have been answered.

_____ _____

Signature of Patient or Responsible Party/Date Witness

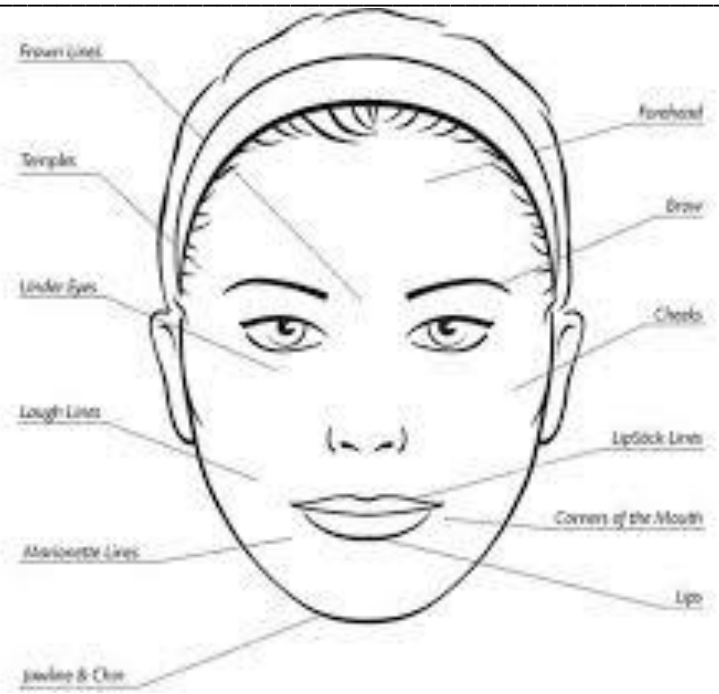
Cosmetic Interest Questionnaire

Patient Name:

Are you Interested in a FREE consultation for any of the below? Please check all that apply

- Botox
- Fillers
- Facial Rejuvenation
- Kybella (double chin)
- Lasers for the skin/ acne scarring
- Wrinkles/ Fine lines
- Facial Contouring
- Anti-Aging/Skin rejuvenation
- Skin Care Regimen
- Microneedling
- Chemical Peels
- Dark Circles under the eyes
- Laser Hair Removal
- Laser removal of broken blood vessels
- Vivace Treatments (microneedling with radiofrequency)
- Hydrafacials

Other: _____



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