GREEN | Dermatology & Cosmetic Center

Jason Green, DO, FAOCD, FAAD

PATIENT INFORMATION

Date: _____ Referred By: _____

Male/Female _____ Married/Single/Divorced/Widowed: _____

Patient Name: _____

Street Address: _____

City / State / Zip Code: _____

Phone Number: _____ Alternate (cell) Number: _____

Date of Birth: _____ Drives License #: _____

Social Security #: _____ Email: _____

Primary Care Physician: _____

Phone #: _____ City, State: _____

If minor, name of parents(s) / guardian:

_____ Phone Number: _____

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

Responsible Party:

Name: _____ Relationship: _____

DOB: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Alternate #: _____

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INSURANCE INFORMATION

Insurance Company: _____ ID#:

Group #: _____ Insurance Phone Number: _____

Subscriber Name: _____ DOB: _____

Subscriber Relationship To Patient: _____

DISCLOSURE STATEMENT

As a courtesy to you, we will file 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 time of service.

I have spoken with a representative of Green Dermatology & Cosmetic Center and 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/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

260 S.W. Natura Avenue Suite 101 Deerfield Beach, FL 33441

(954) 481-0650 Fax: (954) 481-0651

GREEN | Dermatology & Cosmetic Center
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Intake and History Form

Name: _____ Date: _____

Date of Birth: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

Past Medical History

Select any of the following medical conditions you currently 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
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement

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Intake and History Form

- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Live: Shunt

- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Postate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

_____
_____
_____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Have Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other

_____
_____

Do you wear Sunscreen?
◯ Yes ◯ No

If yes, what SPF? _____

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

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Intake and History Form

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son

Medications

List all current medications:

_____
_____
_____

Allergies

List all allergies and reactions if known:

_____
_____
_____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

Intake and History Form

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other _____

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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.

_____ _____

PATIENT NAME (PRINT) PATIENT SIGNATURE

If completed by a patient's personal representative, please print and sign you name is the space below:

_____ _____

Personal Representative (print) Personal Representative Signature

_____

Relationship to Patient

I HAVE MADE A GOOD FAITH EFFORT TO OBTAIN A WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF GREEN DERMATOLOGY & COSMETIC CENTERS NOTICE OF PRIVACY POLICIES BUT WAS UNABLE FOR THE FOLLOWING REASON:

__ PATIENT REFUSED TO SIGN __ PATIENT UNABLE TO SIGN __OTHER

_____ _____

EMPLOYEE NAME **DATE**

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FINANCIAL POLICY

We are committed to providing quality care to all of our patients. The following is a statement of our Financial Policy, which we require you to read and sign.

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 to you, we will bill your insurance company for your visit and services. You must be familiar with your own insurance terms/contract/coverage. Please be advised that it is your responsibility to verify what your insurance will cover and what it will not.

HMO/REFERRALS: It is your responsibility to obtain a referral from your primary care physician if your insurance carrier requires it for your visits. It is your responsibility to know and understand the requirements of your insurance plan. If you receive treatment that is not covered by your insurance, you will be held responsible for all services rendered.

COLLECTIONS: Payment is due at the time services are rendered. Should your account become a collection problem, the patient/debtor assumes all costs of collection, including but not limited to collection personnel fees, court costs, interest and legal fees. Interest on all accounts over 90 days past due will be 15% of the balance for every 30 days past the 90 days. The interest will accrue on the unpaid balance. You cannot be seen until your collection status has been resolved.

NON-COVERED SERVICES: Cosmetic services are not covered by insurance; payment is due at the time services are rendered. Some medical treatments may not be covered by insurance; it is your responsibility to know whether or not any and all services will be covered. Cosmetic consultations are $150.00 at the time of your visit. This fee can be applied toward any cosmetic service we provide.

PRODUCT/SERVICES: There are no guarantees in medicine. There is no guarantee 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 overbook as most physicians do – your appointment is time saved for you; taking care of patients properly takes time. Therefore, a "**NO SHOW**" **fee of $50.00** will be charged **($100 for surgical/cosmetic appointments)** if an appointment is not cancelled/rescheduled at least 24 hours before your appointment time.

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

PATIENT/RESPONSIBILITY PARTY SIGNATURE **PRINT NAME**

DATE: _____

GREEN | Dermatology & Cosmetic Center

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MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

Patient Name: _____Date of Birth: ____/____/___

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

( ) Spouse (Name/Ph #)_____

( ) Child(ren) (Name/Ph #)_____

( ) Other (Name/Relationship/Ph #)_____

_____

This release of information will remain in effect until terminated by me in writing.

MESSAGES

Please call: _____

( ) my home number ( ) my work number ( ) my cell number

( ) You may leave a detailed message

( ) Please leave a message asking me to return your call

The best time to reach me is: _____

Signed: _____ **Date:** ___/___/____

Witness: _____ **Date:** ___/___/____

COSMETIC INTEREST

Patient Name: _____ **Date:** _____

Email address: _____ DOB: _____

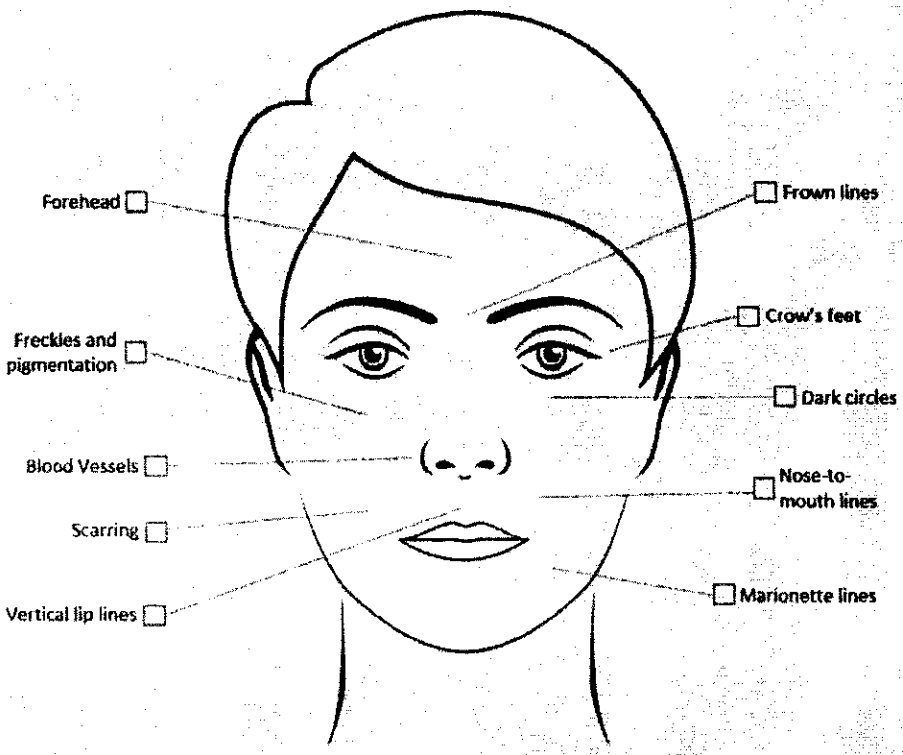
Interested in a FREE cosmetic consultation for any of the below? **(please check all that apply)**

- ☐ BOTOX® Cosmetic
- ☐ FILLERS: Restylane, Bellafill, Radiesse, etc
- ☐ Facial Rejuvenation
- ☐ Kybella **(for double chin)**
- ☐ Facials / Hydrafacials
- ☐ Laser Skin Resurfacing for Acne Scars
- ☐ Acne Scar Revision
- ☐ Wrinkles/fine lines
- ☐ Facial Contouring
- ☐ Other, please specify:

  _____

- ☐ Anti-Aging/Skin Rejuvenation
- ☐ Skincare Regimen
- ☐ Microdermabrasion
- ☐ Microneedling
- ☐ Chemical Peels
- ☐ Dark circles under the eyes
- ☐ Laser Rejuvenation
- ☐ Laser hair removal
- ☐ Laser removal of Blood Vessels
- ☐ Speak with an Aesthetician

With respect to signs of aging, please check the areas of the face that bother or trouble you.



Patient Name: _____ **Patient Signature:** _____

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Surgery During COVID
Patient Authorization and Consent Form

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 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 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, or
- 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 for 1) getting COVID-19 and 2) 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 elective/non-urgent procedure or surgery, I may need to go to an emergency room or a hospital for care. I have been given the option to wait until a later date to have my procedure/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 the procedure/surgery.

Consent to Treatment

_____The first page of this consent form told you about COVID-related risks. If, after reviewing this form, you do not believe that you really understand the risks and choices, **do not sign the form until all questions have been answered.**

_____I understand the facts provided to me on the first page of this consent form. I give my consent for elective/non-urgent procedures and surgeries. 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 and Time

_____

Relationship to Patient (if Responsible Party is not Patient)

_____ _____

Witness Date and Time

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Email address: _____ DOB: _____

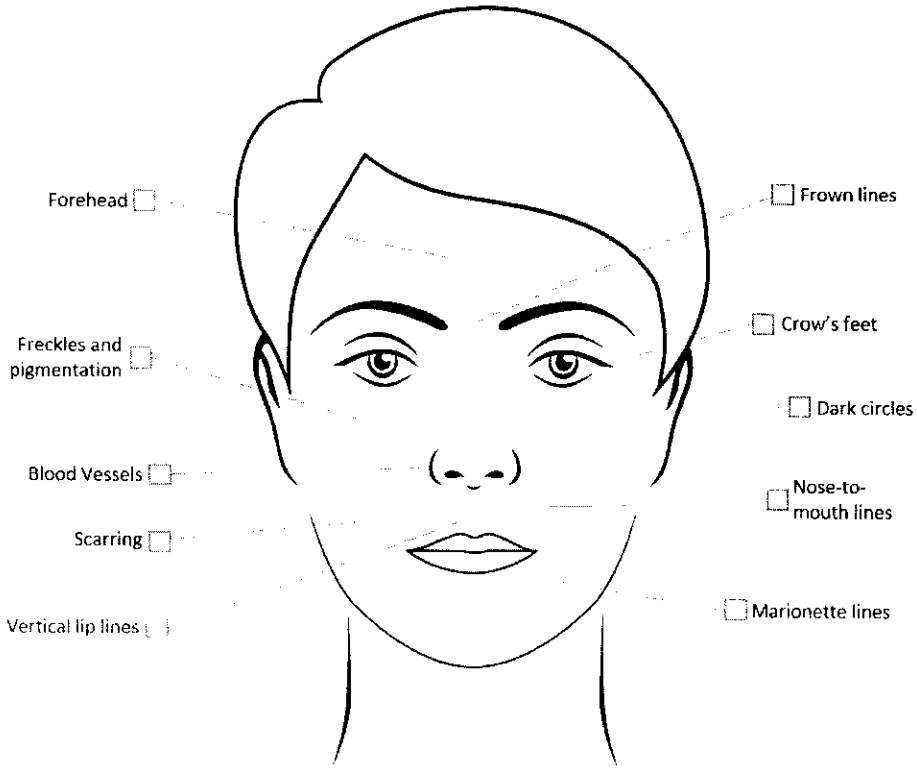
Interested in a FREE cosmetic consultation for any of the below? **(please check all that apply)**

- ☐ BOTOX® Cosmetic
- ☐ FILLERS: Restylane, Bellafill, Radiesse, etc
- ☐ Facial Rejuvenation
- ☐ Kybella **(for double chin)**
- ☐ Facials / Hydrafacials
- ☐ Laser Skin Resurfacing for Acne Scars
- ☐ Acne Scar Revision
- ☐ Wrinkles/fine lines
- ☐ Facial Contouring
- ☐ Other, please specify:

  _____

- ☐ Anti-Aging/Skin Rejuvenation
- ☐ Skincare Regimen
- ☐ Microdermabrasion
- ☐ Microneedling
- ☐ Chemical Peels
- ☐ Dark circles under the eyes
- ☐ Laser Rejuvenation
- ☐ Laser hair removal
- ☐ Laser removal of Blood Vessels
- ☐ Speak with an Aesthetician

With respect to signs of aging, please check the areas of the face that bother or trouble you.



Patient Name: _____ **Patient Signature:** _____

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