



New Patient Demographics

Full Name: _____ Date of Birth: _____ Gender: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____ Social Security Number: _____ Marital Status: _____

Spouse/Next of Kin: _____ Number: _____

Emergency Contact: _____ Number: _____

Cancellation Policy

Berman Cosmetic Surgery and Skin Care Center will require a **24-HOUR** notice of cancellation prior to the scheduled appointment time. If proper notice is not given. You will be charged a cancellation fee of **\$100**.

No Show Policy

Any patient that fails to show up for their scheduled appointment will be charged a **NO SHOW FEE** of **\$100**.

Late Show Policy

Any patient arriving 15 minutes late will only be treated as time allows, with Dr. Berman's schedule. Patients arriving 20 minutes late may be asked to reschedule their appointment.

Return Check Fee

Any bounced checks will result in an additional **\$50** charge to their account

I have read and understand the policies above.

Patient Signature: _____

Date: _____

How Did You Hear About Us?

- Internet Search
- Online Questionnaire
- RealSelf
- Facebook
- Instagram
- Newspaper

- Magazine
- Yelp
- Youtube
- Referral: _____
- Other: _____



Medical History

Patients Name: _____

Date: _____

Please list any medications you presently take:

Do you take the following drugs, and if so how frequently? (This does not include Motrin, Advil, Tylenol, etc.)

Aspirin _____ Anticoagulants _____

Do you have any drug allergies? Yes No

List Allergies

Please list any major operations or medical problems:

Do you presently have, or have you had any of the following in the past 5 years:

(Please Check Off)

- | | | |
|-----------------------------------------------|----------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Drug Dependency | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Photosensitivity | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Angina | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Pulmonary Embolus | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Herpes |

Do you live alone? Yes No

Are you a smoker? Yes No If yes, how much? _____

Is it possible that you are pregnant? Yes No

If you are considering laser hair removal, have you:

1. Taken Accutane in the past year? Yes No
2. Had electrolysis or laser treatment to this area before? Yes No

Signature of Patient: _____

Date: _____



HIPAA Information & Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides a safeguard to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services (www.hhs.gov).

We have adopted the following policies:

1. Client information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers as necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, client records, PHI, and other documents or information.
2. It is the office policy to remind clients of their appointments. We may do this by telephone, e-mail, U.S. mail, text, or any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology, as well as our office promotional material that you might find valuable or informative.
3. The practice utilizes several vendors who may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies in normal performance of their duties.
5. You agree to bring any concerns or complains regarding privacy to the attention of the office manager or the doctor.
6. We agree to provide client's access to their records in accordance with state and federal laws.
7. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the client.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ on ____/____/2018 do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____