NOVICE GROUP DERMATOLOGY

Fred Novice, M.D., F.A.A.D
Karlee Novice, M.D., F.A.A.D

<u>Patient Information -</u> (Please Print Clearly)

Name: ________________________________ DOB: _______________ Male ☐ Female ☐

Address: ____ City: ______________ State____

Zip: ___________ Phone: (Home)_____________ (Work)_____________

(Cell)____________________ Employer: _________________________

Email Address: ____

Referred By: ___________________________

Emergency Contact: Name_________________________ Phone: _______________________

Authorization to Release Information to Your Emergency Contact: ______________________
Signature

Relationship to Patient ________________________

This office participates in many insurance plans. If Drs Fred and Karlee Novice, M.D. are contracted with your insurance company we will accept their negotiated rate for the charges billed, however, you will be responsible for any balance deemed patient responsibility/non payable/not covered by your insurance. There are a variety of deductibles and copays which are the responsibility of the patient or responsible party and are collected on the date of service when permitted. Our office will bill the total charges showing the payment received. If no amount is applied to the deductible or copay you will be reimbursed either by our office or your insurance company. If the service is rejected by your insurance company, you or the responsible party will be responsible for all fees. Please keep in mind that many insurance companies determine the fee by diagnosis and procedure not by time spent or complexity. Remember all insurance claims are subject to individual plan terms and provisions.

Authorization to Release Information: The undersigned hereby authorizes Drs Fred and Karlee Novice, M.D. to release all information pertaining to patient's treatment to his/her insurance company or companies and to any other Physician or Health Care Providers to whom the undersigned may be referred. I authorize Drs Fred and Karlee Novice M.D. to process claims and request payment to be assigned to Fred and/or Karlee Novice, M.D.

Drs Fred and Karlee Novice, M.D. may disclose pertinent health information about me when required to do so by federal, state, or local agencies or in response to a court or administrative order in response to a subpoena. I acknowledge receipt of my notice of privacy practices for the office of Novice Group Dermatology.

Patient Signature: ______________________________________ Date: ____________________

Responsible Party: ______________________________Relationship: ______________________
(Legal Guardian)

NO CHANGES Signature ___________________________________Date__________________

NO CHANGES Signature ___________________________________Date__________________

NO CHANGES Signature ___________________________________Date__________________

Medical History

(Please Print)

Name: ________________________________ Date: ____________________

Do you scar abnormally e.g. Thick abnormal scar (Keloid)? Yes No

Do you have an abnormal bleeding tendency? Yes No

Have you noticed a change in any spots or “moles” on your face or body? Yes No

Have you had gold injections for Rheumatoid Arthritis? Yes No

List all current medications, ***including over the counter medications*** you are taking:

____

Do you or anyone in your family have a history of: Melanoma Skin Cancer

Please list all major operations: ____

Please **CIRCLE** any of the following drugs that you are allergic to:

Penicillin, Sulfa, Mycins, Anesthetic (Novocain)

Other drug allergies not listed above____

Have you ever had X-ray therapy (“Radiation”) for a malignancy or skin conditions? Yes No

Please **CIRCLE** if there is a family history of:

Hay fever, Eczema, Asthma, Allergies, Diabetes, Skin cancer,

Other diseases: ____

Please check any of the following you have a history of:

Accutane Therapy		HIV/AIDS	
Anticoagulants/Aspirin		Hives/Urticaria	
Auto Immune Disorder		Hormone Problems	
Cold Sores/Herpes		Laser resurfacing/Dermabrasion	
Dental Filling/Metal pins		Pacemaker	
Diabetes		Recent Cosmetic Surgery	
Heart Disease		Seizures	
Hepatitis		Sensitivity to light	
High blood pressure		Thyroid Disease	

If yes to any of the above, please explain____

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: ______________________________ Date: ______________________

Health issues and procedures or products of interest to you (please check all that apply).

BOTOX® Cosmetic (Botulinum Toxin Type A)
Refyne®/Restylane® Filler
Juvederm® Filler
Other Hyaluronic Acid Fillers
Liver Spots/Age Spots/SunSpots
Micro-Dermabrasion
Acne and Beta Peels
Chemical Peels
Double Chin – Kybella® Treatment
Excessive Underarm Sweating
Microneedling +/- PRP
Vampire Lift with PRP
Skin Care Advice
Skin Care Products
Sunscreen Advice
Skin Rejuvenation
Facial and Eye Treatments
Ear Lobe Repair Surgery
Laser Hair Removal
Laser for Facial Vein Removal
Latisse® for thicker eyelashes
Grinding Teeth – Botox® for masseter muscle
Thinning Hair – PRP Treatments
Other, please specify ____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

Would you like to be contacted about new products or procedures provided in our office? □ Yes □ No

2. Do you prefer being contacted by phone, standard mail, or email?

□ Phone □ Standard Mail □ E-mail ______________________________
Please print clearly

If by phone, which number do you prefer we use?

□ Home__________________ □ Mobile__________________ □ Office __________________

If you prefer phone contact, do we have your permission to leave a message either by voicemail or with a person if you are unavailable when we call?

□ Yes □ No

Comments____

Please know that we will only contact you by your preferred means of communication.

Signature________________________________ Date____________________

Thank You Very Much!

For Treatment: We will use medical information about you to provide you with medical treatment and services. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.
(This office requires a signed authorization for release of medical information to other physicians or medical facilities, patient, patient's family / representative, insurance company other than the patient's insurance on date of service).

EXHIBIT P4:
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

PRACTICE NAME: NOVICE GROUP DERMATOLOGY

I am a patient of NOVICE GROUP DERMATOLOGY; I hereby acknowledge receipt of NOVICE GROUP DERMATOLOGY's Notice of Privacy Practices.

I give my permission to the staff of NOVICE GROUP DERMATOLOGY to leave a message for me on my email, voice mail or answering machine or send U.S. mail regarding my healthcare, follow up care and accounting.

I give permission to the staff of NOVICE GROUP DERMATOLOGY to share information regarding my healthcare and accounting to the following individuals:

Please select, at least, one option below:

☐ No one else (staff will speak with patient only, will only leave message to call the office of : Novice Group Dermatology)

☐ Spouse: Print Name: ______________________________________ Telephone: ________________________

☐ Child: Print Name: ____ Telephone: ________________________

☐ Other: Print Name: _______________________________________ Telephone: ________________________

Patient Name (PLEASE PRINT): ____

****Patient Signature:** ____ Date: _____/_____/_____

Patients under the age of 18/ Legal Guardian

I am a parent or legal guardian of : (Print **PATIENT'S** name) ____

I hereby acknowledge receipt of NOVICE GROUP DERMATOLOGY's Notice of Privacy Practices with respect to the patient.

Name (PLEASE PRINT): ____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

****Parent / Legal Guardian Signature:** _____________________________________ Date: ___/___/___