

# NOVICE GROUP DERMATOLOGY

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## Patient Information - (Please Print Clearly)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

(Work) \_\_\_\_\_ Employer: \_\_\_\_\_

Email Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone: \_\_\_\_\_

Authorization to Release Information to Your Emergency Contact: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

This office participates in many insurance plans. If Novice Group Dermatology is 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 party responsible 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 terms and provisions.

Authorization to Release Information: The undersigned hereby authorizes Novice Group Dermatology, 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 Fred M. Novice M.D. to process claims and request payment to be assigned to Novice Group Dermatology.

Novice Group Dermatology, 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:

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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).

<input type="checkbox"/> BOTOX® Cosmetic (Botulinum Toxin Type A)	<input type="checkbox"/> Skin Care Advice
<input type="checkbox"/> AHA and Glycolic Peels	<input type="checkbox"/> Skin Care Products
<input type="checkbox"/> Birthmarks	<input type="checkbox"/> Refyne®/Restylane® Filler
<input type="checkbox"/> Skin Rejuvenation	<input type="checkbox"/> Juvederm® Filler
<input type="checkbox"/> Liver Spots/Age Spots	<input type="checkbox"/> Sunscreen Advice
<input type="checkbox"/> Micro-Dermabrasion	<input type="checkbox"/> Facial and Eye Treatments
<input type="checkbox"/> Acne and Beta Peels	<input type="checkbox"/> Laser Hair Removal
<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Laser for Facial Vein Removal
<input type="checkbox"/> Double Chin – Kybella® Treatment	<input type="checkbox"/> Latisse® for thicker eyelashes
<input type="checkbox"/> Excessive Underarm Sweating	<input type="checkbox"/> Grinding Teeth – Botox® for masseter muscle
<input type="checkbox"/> Microneedling / MicroPen	<input type="checkbox"/> Thinning Hair – PRP Treatments
<input type="checkbox"/> Vampire Lift with PRP	
<input type="checkbox"/> 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.

<i>Younger Than</i>	<i>True Age</i>	<i>Older Than</i>		
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.

<i>Not Concerned</i>	<i>Somewhat Concerned</i>	<i>Very Concerned</i>		
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**

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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, answering machine, text (SMS) 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: \_\_\_\_ / \_\_\_\_ / \_\_\_\_