Main Line Center for Laser Surgery
32 Parking Plaza, Suite 200
Ardmore, PA 19003

THIS PATIENT INFORMATION FORM IS PART OF YOUR MEDICAL RECORD AND MUST BE COMPLETED IN ITS ENTIRETY

PATIENT INFORMATION FORM

NAME ______________________________
(Last) **(First)** **(Middle)**

SS#__________________ **BIRTHDATE**__________________ **MARITAL STATUS: S M D W**

GENDER ASSIGNED AT BIRTH__________ **GENDER IDENTITY**______________ **PREFERRED PRONOUN**__________

HOME ADDRESS ______________________________
(Street) **(Apt)** **(City)** **(State)** **(Zip)**

HOME PHONE__________________ **E-MAIL** __________________

WORK PHONE__________________ **CELL PHONE**__________________

OCCUPATION______________________________

EMPLOYER NAME______________________________

RESPONSIBLE PARTY INFORMATION: ***(IF OTHER THAN PATIENT)***

NAME______________________________
(Last) **(First)** **(Middle)**

RELATIONSHIP TO PATIENT______________________________

SS# OF INSURED__________________ **BIRTHDATE OF INSURED**__________________

HOME ADDRESS______________________________
(Street) **(City)** **(State)** **(Zip Code)**

HOME PHONE__________________

☐ **I HAVE NO INSURANCE COVERAGE (*PLEASE CHECK IF APPROPRIATE)***

REFERRED BY ☐***PHYSICIAN*** ☐***FRIEND*** ☐***INTERNET*** ☐***OTHER***__________________ **PHONE #**__________

ADDRESS ______________________________

PRIMARY CARE PHYSICIAN __________________ **PHONE #**__________

ADDRESS ______________________________

EMERGENCY CONTACT __________________ **RELATIONSHIP** __________

PHONE______________________________

I do hereby agree to pay the full and entire amount of the **consultation fee in addition to all bills for services rendered**.

____
(Sign Name) (Date)

As a member of a managed care group, I assume all responsibility for any services rendered that are not a part of my referral, whether or not covered or paid by my insurance, and **I will pay for those services at the time they are rendered**.

____
(Sign Name) (Date)

WORKER'S COMPENSATION AND OTHER PERSONAL INJURY TESTIMONY IN COURT

In order to provide the best possible service, care and availability to all of our patients, **it is our policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action**.

____
(Sign Name) **(Date)**

Specialized Care

I understand that the Main Line Center for Laser Surgery is a tertiary referral practice. The physicians at our center will evaluate the specific problem for which you have been referred or have sought treatment. General dermatologic care and evaluation is the responsibility of the referring or primary physician. If you require a referral to a general dermatologist, please notify our office.

____
(Sign Name) **(Date)**

Reason for visit____

How long have you had this problem?____

Name of General Dermatologist____

Do you see a Skin Care specialist or Esthetician?____

Have you recently had any other treatments such as Botox or fillers?____

Have you ever been on Accutane? YES NO **If yes please also inform the doctor verbally**

If you were on Accutane when____

Do you have or have a history of **Cold Sores**? NO YES

Do you have or have a history of Scarring or Keloids? NO YES

Have you recently had a hormonal work-up for excessive hair growth? NO YES If yes when____

Do you have regular menstrual cycles? NO YES

Do/have you ever had permanent makeup/tattoos? NO YES If yes please also inform the doctor verbally

If yes where? Eyebrows Eyeliner Lip liner Other____

Have you ever had Gold Therapy? NO YES If yes please also inform the doctor verbally

Are you pregnant at this time? NO YES

Do you faint when having blood drawn? NO YES

SOCIAL HISTORY: ***(CHECK ALL THAT APPLY)***

Do you smoke? ☐ NO ☐ YES - Frequency______________________

Do you use recreational drugs? ☐ NO ☐ YES - Frequency______________________

Do you drink alcohol? ☐ NO ☐ YES - Frequency______________________

DRUG ALLERGIES: ***(LIST TYPE OF REACTION)***

☐ ANESTHETICS______________________

☐ CODEINE______________________

☐ PENICILLIN______________________

☐ TETRACYCLINE______________________

☐ ASPIRIN______________________

☐ ERYTHROMYCIN______________________

☐ SULFA______________________

☐ OTHERS, ***please list*** **______________________**

NON-DRUG ALLERGIES: ☐ LATEX

☐ OTHER ***(SPECIFY)*** **______________________**

PRE-MEDICATION REQUIRED PRIOR TO SURGERY ☐ NO ☐ YES - ***List drug, dosage & duration*** **______________________**

PRESENT/PAST MEDICAL HISTORY: ***(LIST CONDITIONS AND DATE)***

____

____

ARE YOU CURRENTLY TAKING MEDICATION?

☐ YES ☐ NO IF SO, PLEASE LIST:______________________

SURGICAL HISTORY: ***(LIST TYPE, REASON FOR SURGERY, DATE, SURGEON)***

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY OF PATIENT ***(CHECK ALL THAT APPLY; USE C. IF CURRENT, USE P IF PAST)***

CONSTITUTIONAL SYMPTOMS:

____ Fever ____ Hair loss
____ Weight loss ____ Weight gain
____ Chills ____ Tremor
____ Nutritional Deficiencies
____ Other, specify_______________

EYES:

____ Cataracts ____ Glaucoma
____ Eyestrain ____ Blurring
____ Inflammation
____ Wear glasses
____ Wear contacts
____ Other, specify_______________
Date of last eye exam_______________

EARS, NOSE, MOUTH, THROAT:

____ Hearing difficulty
____ Pain ____ Discharge
____ Tinnitus (ringing in ears)
____ Dizziness ____ Wear hearing aid
____ Sinusitis ____ Postnasal drip
____ Obstruction
____ Gum Disease
____ Chronic sores
____ Herpes simplex infections
____ Soreness ____ Redness
____ Hoarseness
____ Other, specify_______________

CARDIOVASCULAR:

____ Stroke ____ Palpitation
____ Pacemaker ____ Rheumatic Fever
____ Faintness ____ Pain
____ High blood pressure
____ Heart surgery
____ Edema (swelling)
____ Heart valve replacement
____ Other, specify_______________

INFECTIOUS:

____ HIV Positive ____ AIDS Virus
____ Hepatitis

RESPIRATORY:

____ Asthma ____ Chest pain
____ Emphysema ____ Tuberculosis
____ Lung disease
____ Breathing disorder
____ Bronchitis, chronic
____ Sputum, with blood
____ Cough, chronic
____ Upper respiratory infection, chronic
____ Other, specify_______________

GASTROINTESTINAL:

____ Ulcer ____ Pain
____ Nausea ____ Constipation
____ Diarrhea ____ Vomiting
____ Appetite decrease
____ Colon/intestinal disorder
____ Other, specify_______________

GENITOURINARY:

____ Discharge ____ Urgency
____ Sores ____ Incontinence
____ Hesitancy
____ Herpes simplex infections
____ Other, specify_______________

MUSCULOSKELETAL:

____ Arthritis ____ Lupus
____ Joint pain ____ Lupus of the skin
____ Weakness ____ Joint swelling
____ Joint replacement
____ Cold sensitivity
____ Other, specify_______________

INTEGUMENTARY:

____ Skin cancer(s)
____ Acne ____ Hives
____ Warts ____ Psoriasis
____ Eczema ____ Cystic Acne
____ Loss of Pigment
____ Contact dermatitis
____ Malignant Melanoma
____ Scarring/keloids
____ Herpes simplex (cold sores)
____ Herpes Zoster (shingles)
____ Other, specify_______________

NEUROLOGICAL:

____ Headaches ____ Convulsions
____ Seizures ____ Migraine headaches
____ Epilepsy ____ Fainting spells
____ Memory loss
____ Other, specify_______________

PSYCHIATRIC:

____ Stress ____ Depression
____ Nightmares ____ Insomnia
____ Anxiety ____ Suicidal Tendency
____ Treatment of psychological disorder
____ Other, specify_______________

ENDOCRINE:

____ Thyroid disorder
____ Diabetes mellitus
____ Excessive hair, face/body
____ Other, specify_______________

HEMATOLOGIC/LYMPHATIC:

____ Anemia ____ Bruise easily
____ Blood clots ____ Excessive bleeding
____ Other, specify_______________

ALLERGIC/IMMUNOLOGIC:

____ Asthma ____ Frequent infections
____ Allergies ____ Thyroiditis
____ Vitiligo ____ Addison's Disease
____ Pernicious anemia
____ Hay Fever
Other, specify_____________

MALES ONLY:

____ Urinary difficulties
____ Prostatic problems

FEMALES ONLY:

____ Chronic vaginal infections
____ Currently pregnant
____ Currently taking oral contraceptives
Date of last menses_________

CANCER(S): ***(LIST TYPE, DATE, TREATMENT)***

____

____

DO YOU HAVE ANY FAMILY HISTORY OF SKIN CANCERS/MELANOMA?_______________________________________

PATIENT INFORMATION FORM

THE PRACTICE FINANCIAL POLICY WILL BE GIVEN TO PATIENTS AT THE TIME OF REGISTRATION. ALL PATIENTS MUST SIGN THIS FORM.

OUR PRACTICE FINANCIAL POLICY

The physicians and staff at our office are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Unless other arrangements have been made by either yourself or your health coverage carrier, full payment is due at the time of service. For your convenience, we accept Visa, MasterCard, American Express, Discover, Cash and Personal checks.

YOUR INSURANCE

We have made prior arrangements with some insurers and other health plans. We will bill those plans with whom we have an agreement and will collect any required co-payment at the time of service. The copayment will be collected when you arrive for your appointment. In the event your health plan determines a service to be Anot covered@, you will be responsible for the complete charge. In that event, you will receive a statement at the time of service and payment is due at the time of service.

If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare a statement for you to attach to your insurance claim form for processing of payment. In this case, the insurance carrier will send the payment directly to you. Therefore, charges for your care and treatment are due at the time service is rendered.

Any balance due is your responsibility and is due upon receipt of a statement from our office.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

MISSED APPOINTMENTS

In order to provide the best possible service and availability to all our patients, we ask that you please call us as early as possible if you know you will need to reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its items. I also understand and agree that such terms may be amended from time-to-time by the practice.

____

(Signature of the Patient or Responsible Party) *(Date)*

____

(Please Print the Name of the Patient)

Main Line Center for Laser Surgery
32 Parking Plaza, Suite 200
Ardmore, PA 19003
(610) 645-5551

OUR CANCELLATION POLICY

We do understand that there are times when you are unable to keep an appointment and need to reschedule. We ask that you kindly advise us at least 24 hours in advance. This will enable us to fill the appointment slot with someone from our wait list, and you will NOT be charged.

However, if you cancel an appointment within 24 hours or fail to show up for an appointment, you will be required to pay in full to make a future appointment. If you subsequently fail to provide adequate notice or fail to show up again, your payment will be held and NOT refunded and NOT put towards future appointments.

Thank you in advance for your cooperation.

______________________________ ______________________

Patient Signature Date

Notice of Privacy Practices
This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information
Please Review It Carefully

Effective September 23, 2013

Introduction

As a covered entity, as defined under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, Main Line Center for Laser Surgery (the "Practice"), we are required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices (the "Notice") sets forth our obligations and your rights regarding the use and disclosure of your protected health information. Protected health information is individually identifiable health information that the Practice or its business associates maintain or transmit in any form or medium, including verbal conversations and written or electronic information. Individually identifiable health infomrntion is infomrntion that identifies you, or could reasonably be used to identify you, and that relates to your past, present or future (a) physical or mental health, (b) provision of health care, or (c) payment for such health care.

The Practice's Duties Regarding This Notice

The Practice must give you this Notice to explain the uses and disclosures of your protected health information, to advise you of your rights with respect to your protected health information, and to explain the Practice's legal duties and privacy practices with respect to your protected health information under HIPAA and ,i:s:lated regulations. The Practice is required to abide by the temls of the Notice currently in effect. The Practice reserves the right to change the terms of this Notice and make the new provisions applicable to all protected health information that it maintains. In the event the Practice changes this Notice in a significant manner, the Practice will distribute a revised notice within 60 days of the effective date of the change. Remember- the Practice does not maintain all of your medical information. Your health care plan (e.g., health insurance) also maintains some of your information. You should contact your health plan directly if you have any questions about medical information maintained by them.

How Your Protected Health Information May Be Used or Disclosed For Treatment, Payment and Health Care Operations

The confidentiality of your protected health information is very important to us. The Practice is able to use or disclose your protected health information for treatment, payment, and health care operations as explained below. Other uses and disclosures of your protected health information are explained in later sections of this Notice.

Treatment

Treatment means the coordination or management of health care and related services by one or more health care providers. For example, the Practice may disclose, for treatment purposes, protected health information to a health care provider such as another physician, hospital, pharmacist or nurse involved in your care.

Payment

The Practice may use and disclose protected health information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

Health Care Operations

We may use and disclose protected health information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the dermatological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Other Information

The Practice will take reasonable steps and apply safeguards to limit the permitted or required uses and disclosures of your protected health information to the minimum amount necessary to accomplish the task. The descriptions listed above do not include every possible use or disclosure that is permitted or required by law. The descriptions given are only intended to provide you with information about the various ways that the Practice may use or disclose your protected health information and to give you some examples.

Other Permitted or Required Uses and Disclosures

Other than treatment, payment and health care operations, the Practice is permitted or required by law to use or disclose your protected health information in other ways described below.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services

The Practice also may use your protected health information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Research

Under certain circumstances, we may use and disclose protected health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose protected health information for research, the project will go through a special approval process and there are limitations on how your protected health information may be used for research purposes. The Practice may also seek your authorization for the use of PHI for research.

To You or Certain Other Individuals

Your own protected health information may be disclosed to you or to your personal representative who is an individual, under applicable law, authorized to make health care decisions on your behalf. For example, a parent is generally the personal representative of a minor child. This Practice may disclose your protected health information to a family member, other relative, close personal friend or other person identified by you. The protected health information that is disclosed must be directly relevant to the family member or other person's involvement with your health care. The requirements are that you must be present or available prior to the use or disclosure and (a) agree, (b) have the opportunity to object or (c) the Practice may determine, based on the circumstances and its professional judgment, to make the disclosure. If you are not present or are incapacitated, the Practice may use its professional judgment to determine whether the disclosure of protected health information is in your best interests. If the Practice makes this determination, it may disclose only your protected health information that is directly relevant to the individual's involvement with your health care.

The Practice may, in certain situations, use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative or other person involved in your care of your location or condition. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

To Business Associates

The Practice works with different organizations that perform a variety of services on its behalf. The organizations, or Business Associates, perform specific functions and services for the Practice. For example, we may use another company to perform billing services on our behalf. Services also include consulting, legal, financial, and management activities. The Practice may disclose protected health information to its Business Associates for the permitted functions or services, but only if the Practice receives assurances through a written contract or agreement that the Business Associate will properly safeguard the information.

In A Limited Data Set

A limited data set contains protected health information from which direct identifiers such as name and social security number have been removed, but indirect identifiers such as date of service have been kept. Information in a limited data set may be used or disclosed for research, public health or health care operations. The information may be disclosed only if the Practice has entered into an agreement with the recipient that establishes its permitted uses or disclosures.

As Required by Law and for Public Benefit

Protected health information may be:

- Used or disclosed as required by law and in compliance with the requirements of the law, including disclosures to the Secretary of Health and Human Services for the purpose of determining compliance with the privacy standards;
- Disclosed to an authorized public health authority for specified reasons such as to prevent or control disease, injury, or disability; to report child abuse or neglect; to report the safety or effectiveness of FDA-related products such as medication; and to notify a person at risk of contracting or spreading a communicable disease;
- Disclosed to an authorized government authority if the disclosure is about victims of abuse, neglect, or domestic violence;
- Disclosed to authorized health oversight agencies for activities such as audits, investigations, inspections, and licensure requirements necessary for oversight of the health care system and various government benefit programs;
- Disclosed for judicial and administrative proceedings such as responses to court orders and court-ordered warrants, to subpoenas issued, to discovery requests, or other lawful processes;
- Disclosed to a law enforcement official for a law enforcement purpose;
- Disclosed to federal officials for national security reasons;
- Disclosed to coroners or medical examiners for purposes of identifying a deceased individual and to funeral directors to carry out their duties;
- Used or disclosed to an organ and tissue procuring or transplant organization to facilitate donation transplantation;
- Used or disclosed for research purposes if certain requirements are met;
- Used or disclosed as necessary to prevent or lessen a serious or imminent threat to the health and safety of person or the public;
- Disclosed to comply with workers' compensation or other similar laws;
- Disclosed to comply with laws related to military service or veterans' affairs; and
- Disclosed to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

In most situations, reasonable measures will be taken to limit the use and disclosure of protected health information to the individuals who need it and to the amount necessary to perforn1 a particular function.

Other Uses and Disclosures Only in Accordance with Your Authorization

Other than the uses or disclosures of your protected health information that are permitted or required by law, the Practice may not use or disclose your protected health information unless you authorize the Practice to do so by completing a written authorization. As a result, uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information will be made only with your express written authorization. Please note that the Practice does not use your protected health information for marketing or fundraising purposes. You may revoke your authorization at any time to stop future uses or disclosures; however, the revocation will not apply to the extent that the Practice has already made uses or disclosures in reliance on your authorization. Your revocation will also not be effective to the extent that the authorization was given as a condition of obtaining insurance coverage if another law gives the insurer the right to contest a claim under the policy or the right to contest the policy itself. Once your protected health information has been disclosed pursuant to your authorization, the privacy protections under HIPAA may no longer apply to the disclosed health information and that information may be re-disclosed by the recipient without your or the Practice's knowledge or authorization.

Your Individual Rights Regarding Your Protected Health Information
You have certain rights with respect to your protected health information, as described in detail below. You may exercise your rights by submitting a written request that specifies the right(s) you wish to exercise. Requests should be sent to the Human Resources Department. Contact information is provided at the end of this Notice.

Right to Request Restrictions
You have the right to request restrictions on certain uses or disclosures of your protected health information for the purposes of treatment, payment or health care operations. The Practice is not required to agree to any restriction that you request. You will be notified if your request is accepted or denied. The Practice may agree to appropriate restrictions if your protected health information pertains to health care items or services that you paid for entirely out-of-pocket and the disclosure of protected health information is for purposes of payment or health care operations.

Right to Receive Confidential Communications
You have the right to request receipt of confidential communications of your protected health information from the Practice by reasonable alternative means or at an alternative location. For example, you may not want messages left on voicemail or sent to a particular address. To request confidential communications by alternative means or at an alternative location, you must submit your request in writing with the reason(s) for the request. If appropriate, your request should state that the disclosure of all or part of your protected health information by non-confidential communications could endanger you. The Practice will accommodate reasonable requests and will notify you appropriately.

Right to Inspect and Copy
You have the right to inspect and copy your protected health information that is contained in a "designated record set" that is, enrollment, payment, claims determinatiol'r, case or medical management records or records that are used to make decisions about you and that are maintained by the Practice, in a form and format that you request, to the extent such form and format is readily producible by the Practice. The Practice may charge you a reasonable cost-based fee for the labor, supplies and postage associated with your request. There are some exceptions to your right to inspect and copy, such as:

- Psychotherapy notes (if any),
- Information compiled in anticipation of a civil, criminal, or administrative action or proceeding, and
- Situations in which a licensed health care professional determines that releasing the information may have a harmful effect on you or another individual.

In certain circumstances, if you are denied access to your protected health information, you may request a review of the denial. You may request that the Practice send a copy of your protected health information directly to a designated person.

Right to Request an Amendment
If you believe that protected health information about you that is contained in a "designated record set" is inaccurate or incomplete, you have the right to request that it be amended. Your request must be in writing and you must provide a reason to support your request.

The Practice may deny your request for an amendment if your request is not in writing or if you do not provide a reason for your request. Your request will also be denied if the Practice determines:

- The information was not created by the Practice (unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on your request),
- The information is not maintained by or for the Practice or is not part of the information which you would be permitted to inspect and copy,
- Access to the information is restricted by law, or
- The information is accurate and complete.

If your request is denied, you will receive written notification of the denial explaining the basis for the denial and a description of your rights.

Right to an Accounting of Disclosures
You have the right to receive a listing of, or an accounting of, disclosures of your protected health information made by the Practice. Certain disclosures do not have to be included in this accounting, including the following:

- Those made for treatment, payment or health care operations,
- Those made pursuant to your written authorization,
- Those made to you,
- Those that are incidental to otherwise permitted or required disclosures,
- Those made as part of a limited data set,
- Disclosures to individuals involved in your care, and
- Disclosures for certain security or intelligence reasons and to certain law enforcement officials.

If you request an accounting of disclosures of your protected health information, you will need to specify the dates you want the accounting to cover. The accounting period cannot exceed six years prior to the date of the request. You are entitled to one free accounting in any 12-month period. The Practice may charge for any additional accountings you request within the same 12-month period. The Practice will notify you in advance of any changes.

Right to Receive Notification of a Breach
You have the right to receive a notification from the Practice if there is a breach of your unsecured protected health information.

Right to Receive a Paper Copy
Even if you have agreed to receive this Notice electronically, you have the right to request and receive a paper copy of this Notice from the Practice.

Complaints and Contact Information

Complaints
If you are concerned that your privacy rights have been violated, you may submit a complaint to the Practice by contacting Eric F. Bernstein, MD. The complaint must be in writing and provide a description of why you think your privacy rights were violated. No retaliatory actions will be taken against you for filing a complaint.

You may also file a complaint with the Secretary of Health and Human Services:
Web site: viww.hhs.gov/ocr/hipaa
E-mail: OCRComplaint@hhs.gov.
Address: Region Ill, Office for Civil Rights,
150 S. Independence Mall W, Suite 372,
Public Ledger Building
Philadelphia, PA 19106-9111

Contact Information
Please contact Main Line Center for Laser Surgery in order to:

- Obtain a paper copy or another copy of this Notice,
- Ask questions about this Notice or the Practice's practices regarding protected health information,
- File a complaint,
- Request that disclosure of eligibility status or claim status not be provided to a family member,
- Obtain an Authorization Form, or
- Make a request for individual rights as described above.

The phone number is: (610) 645-5551
The address is: 32 Parking Plaza, Suite 200, Ardmore, PA 19003

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT FORM

By signing below, I acknowledge that I have been provided the Practice Notice of Privacy Practices, which contains a detailed description of the uses and disclosures of my health information and I been given an opportunity to read the Notice.

Signature: ______________________ Date: ______________

Print Name: ______________________

Signature of Authorized Representative (if signing for patient): ______________________

OFFICE USE ONLY
If unable to obtain the patient's signature in acknowledgment of receipt of the HIP AA Notice of Privacy Practices, document the reason below (emergency etc.)

Patient Name: ______________________ Date: ______________

Reason: ____