SOINE DERMATOLOGY
& AESTHETICS

OFFICE POLICIES

Cosmetic vs. Medical Necessity

Your medical insurance **does** cover the discussion of and treatment of **medically necessary conditions**. If you are not sure about a skin lesion - Please **do** ask about it.

Insurance does not cover:

1. Removal of spots for cosmetic purposes - "I don't like the way it looks".
    a. Example: benign moles, overgrown oil glands, small cysts, skin tags, benign keratosis
2. Removal of Benign lesions that are asymptomatic (not tender, itchy, or inflamed).
3. **Discussion** of cosmetic issues
    a. "tell me about what I can do to make my skin look better"
    b. "tell me about skin rejuvenation and how to get rid of my wrinkles"

Requests are frequently made to remove lesions that are **not medically necessary** or **discuss "cosmetic" issues**. In that case, after we have concluded the regular office visit, the medical assistant will provide you with a fee schedule for any non-covered issues. The doctor will return back to your room after seeing the next patient to address these non-covered services. **You will be expected to pay for any "cosmetic" services today in addition to any co-pays/deductibles for insured services.**

GENERAL DERMATOLOGY

All general dermatology appointment cancellations require at least a 48 hours' notice, unless an emergency (documented) arises. Failure to give a 48 hours cancellation notice will result in a $50.00 No-Show fee. The second offense will result in a $100.00 No-Show fee at the discretion of the practice. "No-Show fee" is to be collected prior to scheduling any future appointments. Please call (985) 400-5551 to cancel.

COSMETIC

All cosmetic procedures (30 minutes and up) appointment cancellations require at least 48 hours' notice, unless an emergency (documented) arises. Failure to give 48 hours cancellation notice will result in a $75.00 No-Show dee. "No-Show fee" is to be collected prior to scheduling any future appointments. Please call (985) 400-5551 to cancel.

LATE ARRIVALS

As a courtesy to our patients, we make every effort to see everyone on time. In the event that you arrive late for you appointment, we will make every attempt to see you in a timely manner. However, please understand that patients with scheduled appointments will be seen first. If you cannot wait and would like to reschedule, our patient relations coordinator will be happy to assist you.

I, the undersigned, understand the office procedures as noted above, I have had a chance to have all my questions answered in my satisfaction and agree to abide by the polices listed above.

Patient Name **Date**

SOINE DERMATOLOGY & AESTHETICS

Patient Name: _____ Email: _____

Address: _____ Phone: _____

1. **Dr. Soine offers many procedures to address your skin needs. Please circle your following concerns:**

Loose/"Saggy" Skin	wrinkles	Pore Size	Redness
Brown Spots	Acne Scars	Texture/Tone	Veins
Acne	Unwanted Hair	Asymmetry	Double Chin

Other: _____

2. **Would you like to set up a complimentary cosmetic consultation today?** Yes No

3. **If yes, please circle the following cosmetic dermatology procedures that would like to discuss:**

Ultherapy	Laser Hair Removal	Microneedling	Dermaplane
MicoLaser Peels	Chemical Peels	Extractions	Asclera
Relaxants (Botox, Dysport, Jeuveau)		Fillers (Juvederm, Restylane, and Others)	

4. **Dr. Soine personally researches and selects all medical grade skin care products. Do you use the following skin care products?**

Foaming Acne Wash	Daily Sunscreen	Facial Cleanser	Retinoid
Antioxidant Serum	Moisturizers	Neck Firming Cream	Eye Cream

5. **Would you like to receive information on our upcoming seminars or monthly specials?** Yes No
   If so, are there any topics that are of particular interest to you? Please list those below:

   _____

6. **May we include you on our email list? We will send approximately 1-2 emails per month with important information, specials and events.** Yes No

SOINE DERMATOLOGY
& AESTHETICS

Your Privacy is Important to Us

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I have received a copy of the Notice of Privacy of Soine Dermatology & Aesthetics. I hereby authorize as indicated by my signature below, Soine Dermatology & Aesthetics to use and to disclose my protected health information for any necessary clinical, financial and insurance purpose, as authorized in the Patient Consent form.

Print Name (Circle one: Patient/Parent/Legal Guardian) Signature

Date Address

Please check your preferred means of communication:

____ You may contact me/leave message at my home telephone # _____

____ You may contact me/leave message at my mobile telephone # _____

____ You may contact me/leave message at my work telephone # _____

____ You may send an unencrypted email at: _____

Please list the authorized person with whom we may discuss your protected health information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added/Removed: _____
2. _____ Date Added/ Removed: _____
3. _____ Date Added/Removed: _____

*** FOR OFFICE USE ONLY ***

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____ Initials _____

SOINE DERMATOLOGY
& AESTHETICS

Patient: _____ Age: _____ DOB: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Pharmacy: _____

Reason for Visit: _____

Medical History

Have you ever experienced any of the following?

YES ☐ NO ☐ Arthritis

YES ☐ NO ☐ Asthma

YES ☐ NO ☐ Autoimmune Disease

If yes explain: _____

YES ☐ NO ☐ Bleeding Issues

YES ☐ NO ☐ Cancer

If yes explain: _____

YES ☐ NO ☐ Defibrillator

YES ☐ NO ☐ Diabetes

YES ☐ NO ☐ Heart Attack or Stroke

YES ☐ NO ☐ Heart Disease

YES ☐ NO ☐ Skin Cancer

If yes what type/location: _____

YES ☐ NO ☐ High Blood Pressure

YES ☐ NO ☐ HIV/AIDS/Hepatitis B/Hepatitis C

YES ☐ NO ☐ Kidney Disease

YES ☐ NO ☐ Pacemaker

YES ☐ NO ☐ Thyroid Disease

Other: _____

YES ☐ NO ☐ Actinic Keratosis

YES ☐ NO ☐ Eczema

YES ☐ NO ☐ Keloids

YES ☐ NO ☐ Melanoma

YES ☐ NO ☐ Psoriasis

YES ☐ NO ☐ Family History of Skin Cancer

If yes who & what type: _____

Female patients: Are you pregnant? Nursing? Trying to get pregnant? YES ☐ NO ☐

Please list any surgeries you previously had: _____

_____

Please list any medications/products you are allergic to: _____

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1._____ 3._____ 5. _____

2._____ 4._____ 6. _____

Tobacco Use: YES ☐ NO ☐ **Alcohol Use**: YES ☐ NO ☐ Occasionally ☐ **Recreational Drugs**: YES ☐ NO ☐

Influenza Vaccination YES ☐ NO ☐ **Pneumonia Vaccination** YES ☐ NO ☐

Signature: _____ Date: _____

SOINE DERMATOLOGY
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PATIENT INFORMATION

Patient Name: _____Gender:_____ DOB: _____

Address: _____

Preferred Phone: _____ Other Phone: _____ SSN: _____

Occupation: _____ Employer: _____

Marital Status: _____ Ethnicity: _____ Language: _____ Race: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____

REFERRAL INFORMATION

Who referred you to our practice? Friend Insurance Internet Other

Referring Physician? _____

Who is your Primary Care Physician? _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#_____Group#_____

Insured Name: _____ DOB: _____ Subscriber SSN: _____

Relationship to the insured: Self Child Spouse Other

Secondary Insurance: _____ ID#_____Group#_____

Insured Name: _____ DOB: _____ Subscriber SSN: _____

Relationship to the insured: Self Child Spouse Other

PRIVACY PRACTICE NOTICE & WRITTEN ACKNOWLEDGEMENT FORM

I have been offered a copy of Soine Dermatology & Aesthetics Notice of Privacy Practices.

Signature of Patient/Guardian:

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION

I request payment of authorized insurance benefits be paid to Soine Dermatology & Aesthetics and authorize release of medical information as needed to determine payable benefits for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature of Patient/Guardian:
