Couture Dermatology and Plastic Surgery

Patient Demographic Information

Patient Information:

Patient Name:____ Today's Date: __________
(Last) (First) (Middle)

Address:______________________________ City: __________ State: _____ Zip: _____

Home Phone:(____)__________ Cell Phone:(____)__________ Work Phone:(____)__________

Email: ______________________________ How Did You Hear About Us? __________

Employer (or school, if student): ______________________________ Occupation:__________

Employer's Address: ______________________________

Date of Birth: __________ Age: _____ Gender:_____ Marital Status: _____

Social Security No:__________

Emergency Contact: ______________________ ______________________ (____)__________
(Name) (Relationship) Phone

If patient is a minor, please complete the following:

Responsible Party Name:______________________________ Date of Birth:__________

Relationship to Patient:______________________ Phone #:______________________

Address:______________________________City:__________ State:_____ Zip:_____
(If same as patient, write "Same as Patient")

Email:______________________________

Race: ☐ White or Caucasian ☐ Black or African American ☐ Asian
☐ Hispanic/Latino ☐ Native Hawaiian ☐ American Indian/Alaska Native
☐ Mixed ☐ Other ☐ Declines to provide information

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Patient declines to provide information

Preferred Language: ☐ English ☐ Spanish ☐ Other ______________________

Medical Questionnaire

Name: ______________________

Date: ______________________

Date of Birth: ____/____/______

Do you have or have you ever had any of the following? *Check box if – Yes –*

- ☐ Acne
- ☐ Artificial Joint/Prosthesis/Heart Valve
- ☐ Asthma/Hay Fever/Hives/Sinus Problems
- ☐ Autoimmune Disease (Lupus, Arthritis, etc.)
- ☐ Back Pain
- ☐ Bleeding Disorder
- ☐ Blood Clots or DVT's
- ☐ Blood Transfusions
- ☐ Breast Cancer
- ☐ Cancer
- ☐ Chest Pain/Tightness
- ☐ Cold Sores
- ☐ COPD
- ☐ Diabetes
- ☐ Eczema/Skin Rashes/Skin Infections
- ☐ Epilepsy, Fainting, Blackouts
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Murmur/Mitral Valve Prolapse
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ HIV/AIDS/Blood Borne Infections
- ☐ Keloids
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Sexually Transmitted Disease
- ☐ Skin Cancer
- ☐ Skin Disease
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers (Heart Burn, Gastritis
- ☐ X-ray (Radiation) Therapy

Are you allergic to any medication? (Please list)

____

____

____

List current medications:

____

____

____

Surgeries/Hospitalizations:

Operation	Date	Hospital

Name of your Primary Care Physician:

____

Please Complete Carefully:	Yes	No
Are you currently taking Accutane or have you used Accutane in the past?	☐	☐
Are you in good health?	☐	☐
Are you under a physician's care?	☐	☐
If so, for what condition? ______________		
Name of physician caring for you: ______________		
Do you drink alcohol?	☐	☐
If yes, how many drinks per day/week? ______________		
Do you smoke?	☐	☐
If yes, how much? ______________		
Do you sunbathe or use tanning booths?	☐	☐
Do you need antibiotics before having dental work done?	☐	☐
Do you use sunscreen?	☐	☐
Do you bleed easily for a long time after a cut or extraction?	☐	☐
Do you have an Advance Directive and/or a Living Will?	☐	☐

Signature: ______________________

Date: ______________________

Cosmetic Questionnaire

____ Are you interested in having a cosmetic consultation?**

Are you concerned with:

____ Wrinkles/Volume Loss (smokers lines, frown lines, smile lines, etc)

____ Brown Spots/Discoloration

____ Redness

____ Spider Veins

____ Skin Elasticity

____ Scarring

____ Hair Loss

____ Unwanted Hair

____ Unwanted Moles

____ Body Contouring

____ Breast Augmentation

Please provide your email to receive information regarding products and services we offer:

____

**Cosmetic consultations are specifically scheduled so our provider has sufficient time to spend with you discussing your goals and preferences, and providing guidance to assist you in making the decisions that are perfect for you. Your cosmetic consultation may be booked with our front desk staff. The $150 consultation fee is required in advance to reserve that consult time.

Couture Dermatology and Plastic Surgery

Patient's Name: ______________________ Date: ________

☐ Check here if patient is a minor or otherwise unable to give consent.

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for the purpose of medical teaching, or for publication in medical textbooks or journals, as I have designated below. I understand that my consent or refusal to consent to these medical photographs will in no way affect the medical care I will receive; however, the tracking of patient progress may be inhibited. If I have questions or if I wish to withdraw my consent in the future, I may contact:

Couture Dermatology and Plastic Surgery
Attn: Administration 9950 W. Flamingo Road, Ste. 105, Las Vegas, NV 89147
Phone: 702-998-9001 E-Mail: info@couturemedical.com

By signing below I confirm that this consent form has been explained to me in terms which I understand.

☐ I consent for these photographs to be used in medical publications, including medical journals, textbooks and electronic publications. I understand that the image may be seen by members of the general public in addition to scientists and medical researchers who regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

______________________ ______________________

Patient signature *Witness*

☐ I agree for my image to be shown for teaching purposes AND to be used for my medical record BUT NOT for medical publication.

______________________ ______________________

Patient signature *Witness*

☐ I do not consent to any of the above (I consent to medical records ONLY).

______________________ ______________________

Patient signature *Witness*

For patients between the ages of 7 and 18 years, a signature below indicates that the information in the consent form has been explained to me, and I consent to the use of these images as outlined above.

______________________ ______________________

Patient Name *Patient Age*

______________________ ______________________

Legal Guardian's Name (Printed) *Legal Guardian's Signature*

Patient's Name: ______________________ Date of Birth: ____________
(please print legibly)

Primary Insurance

Insurance Name: ______________ Pol or ID # ____________ Grp # ________

Policy Holder's Name: ______________________ Date of Birth: ____________

Relation to patient: ______________ Social Security No: ______________

Secondary Insurance

Insurance Name: ______________ Pol or ID # ____________ Grp # ________

Policy Holder's Name: ______________________ Date of Birth: ____________

Relation to patient: ______________ Social Security No: ______________

NOTE: IF MEDICARE IS SECONDARY, YOU MUST COMPLETE THE MEDICARE SECONDAY PAYER QUESTIONNAIRE – PLEASE ASK FRONT DESK STAFF FOR FORMS.

Release of Information and Assignment of Benefits

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to Marvin D Spann, MD, PLLC, dba Couture Dermatology and Plastic Surgery. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid by said insurance. I hereby authorize said assignee to release all medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. ______________ (***Initials***)

Payment Policy

Payment is required for all services at the time they are rendered. Any applicable co-payments, co-insurance and/or deductible amounts will be collected at the time of service. We accept payment in the form of cash, check and credit card. Your insurance plan will be billed for the charges incurred. Prior authorization does not guarantee payment of claims. If a diagnostic procedure is performed, it is the patient's responsibility to pay any balance due to any outside facility (such as a lab, etc.) utilized to complete and determine the diagnosis for such a procedure. If you are being treated for a condition that is not medically necessary and so is considered cosmetic, payment in full will be collected at the time of service. Should your doctor examine you and document any other conditions that are medical in nature, this examination and any resulting treatment will be billed separately to your insurance company. Depending on your plan, you may be responsible for additional copay and/or deductible amounts. Your signature below signifies your understanding and willingness to comply with these policies. ____________ (***Initials***)

REV 9/23/2022

No Show Fee and Insufficient Funds Fee

A $50.00 "No Show" fee will be charged to your account if you fail to cancel or re-schedule your appointment at least 24 hours in advance. If the appointment is for cosmetic services a $100 fee will be charged.

A $50.00 fee will also be charged for any returned check. ________________ (*Initials*)

Insurance Coverage

If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain and bring this in with you on the day of your appointment. If you do not have a referral number and your insurance requires it, it may be necessary to re-schedule your appointment.

Pharmacy Information

Pharmacy Name: ____

Address: ____

Phone Number: ______________________ Fax Number: ______________________

Acknowledgement

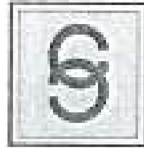
I have read the Payment Policies and the Insurance Coverage policies and procedures described above. I understand them and agree to all these provisions. ___________ (*Initials*)

Written Acknowledgement of Receipt of Privacy Practices Notice, Policies and Procedures

I, ______________________________ (Responsible Party/Patient), have received a copy of Couture
(print name here)

Dermatology and Plastic Surgery's Notice of Privacy Practices. ___________ (*Initials*)

Signed: ____
(Patient or Responsible Party's Signature)



Couture Dermatology and Plastic Surgery Office Policies

Medication and Refills: Please allow up to 48 hours to process refill requests. Requests for new medication may require an appointment be scheduled. **Initials** ________

Patient Portal: Couture Dermatology and Plastic Surgery uses our patient portal to communicate with patients for various reasons. If you need assistance with patient portal registration, please ask one of our front office staff. **Initials** ________

Test Results: Normal results will be published to your patient portal; you will NOT receive a telephone call. If you wish to discuss your results with the physician/physician assistant, an appointment must be scheduled. **Initials** ________

Late Appointments: Any patient arriving 15 minutes late to their appointment is subject to their appointment being rescheduled. **Initials** ________

Medical Records: A medical release form must be signed. Requests for records may take up to 30 days to process. **Initials** ________

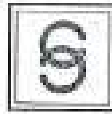
Staff Treatment: Couture Dermatology and Plastic Surgery has a zero tolerance policy for inappropriate conduct. This includes the use of profanity, threatening comments, physical assault, etc. Any patient or guest who behaves in any way that is disruptive or abusive towards staff or Providers will be discharged from the practice. **Initials** ________

The goal of our practice is to provide you with high quality care through exceptional customer service. Please excuse any delays due to emergencies or unforeseen circumstances. We will give you the same time and attention that we give all of our patients.

I understand the office policies and agree to comply with these policies.

______________________________ ______________________________

Signature Date



COUTURE

DERMATOLOGY & PLASTIC SURGERY

PATIENT FORM POLICY

PURPOSE

The purpose of the policy is to ensure that all forms requiring a physician signature are completed in a timely manner and appropriate procedures are followed in the processing of forms.

Information and Procedures

Any documentation that needs to be completed with medical information and requires a physician signature including FMLA, Disability, Insurance Requests

Please READ and INITIAL the following statements:

________ Processing time is 10 to 14 business days. They will be completed in the order they are received. We understand at times there may be an urgent need with some form completion and will do our best to accommodate.

__________ Forms may be dropped off at the office, emailed or faxed. **Prepayment is required before forms are released.**

__________ Blank forms ***will not*** be accepted. Personal information must be completed.

It is our office policy to charge for the completion of any form as follows:

-Processing fee of $35 per form. If needed more urgently we can USUALLY expedite processing to 3-5 days, the fee for rush processing is $45.

-If the form is lost or needs to be revised/updated an additional $25 fee for reprocessing will be applied.

Completed forms: Completed forms may be faxed, mailed or picked up in person.

Patient Signature:________________________________ Date:________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

To our patient – Note - You may refuse to sign this Acknowledgement

I, ______________________________, have received a copy of this
(Patient – Print Name Here)

office's Notice of Privacy Practices.

______________________________ ______________
(Signature) *Date*

For Office Use Only

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

- ☐ The patient refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify):

____

____

____

Couture Dermatology and Plastic Surgery

HIPAA Patient Questionnaire

1. Please list family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

   Name: ______________________ Phone Number: ______________

   Name: ______________________ Phone Number: ______________

   Name: ______________________ Phone Number: ______________

2. Please list family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

   Name: ______________________ Phone Number: ______________

   Name: ______________________ Phone Number: ______________

   Name: ______________________ Phone Number: ______________

3. Please list the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home*** (Confidential Communications):

   ____

   ____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": ☐ Yes ☐ No

5. Please print the telephone number or email address where you want to receive calls/correspondence about appointments, lab and x-ray results or other health care information ***if other than your home***:

   Phone Number: ______________ E-Mail: ____________________________

6. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No

7. I understand the Privacy Protection Act and have been offered a copy of this organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

   Patient's Name: ____

   Please print patient's name or Guardian's name, if patient is under 18 yrs old

________________________________ ____________________

Patient/Guardian Signature Date