

MARYLAND LASER, SKIN & VEIN INSTITUTE, LLC

54 Scott Adam Road, Suite 301 • Hunt Valley, MD 21030 • Ph (410) 666-3960 Fax (410) 666-3981 • www.MDLSV.com

PATIENT INFORMATION RECORD (PLEASE PRINT)

(PATIENT) LAST NAME _____ FIRST _____ MIDDLE INITIAL _____

STREET ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP CODE _____ COUNTRY _____

EMAIL _____ @ _____ . _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ CELL PHONE (_____) _____

DATE OF BIRTH ____/____/____ AGE _____ SEX: MALE / FEMALE SSN# ____ - ____ - ____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ STATE _____ ZIP CODE _____

SPOUSE NAME _____ OCCUPATION _____ DAY PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED / SEPARATED STUDENT: FULL TIME / PART TIME / Not Applicable

HOW DID YOU HEAR ABOUT US? Physician Another patient Internet search Phone Book Print ad _____ Other _____

REFERRING PHYSICIAN _____ ADDRESS _____ PHONE _____

COMPLETE THIS SECTION IF PATIENT IS A MINOR

NAME OF LEGAL GUARDIAN _____ RELATIONSHIP _____ CELL PHONE (_____) _____

STREET ADDRESS _____ CITY _____ STATE _____

ZIP CODE _____ COUNTRY _____ HOME PHONE (_____) _____ WORK PHONE (_____) _____

EMPLOYER _____ OCCUPATION _____ SS# ____ - ____ - ____

EMPLOYER'S ADDRESS _____ STATE _____ ZIP CODE _____

GUARDIANSHIP FOR MINOR

I, the undersigned, on my behalf or that of a minor under my guardianship _____ (patient/minor name), hereby agree to be financially responsible for the cost of the services that the minor is about to receive. I also understand that if the service(s) are not paid in full at the time of service, I hereby authorize Maryland Laser Skin & Vein Institute, LLC or their agent to invoice me for any outstanding balances. Executed this _____ day of _____, 20_____.

Signature of Guardian

Guardian Name

Date

IMPORTANT: This practice does not participate with any insurance plans. For those services that may be reimbursable by health insurance, we will provide you with a copy of today's bill to submit your claim. This will have all of the necessary billing information to process your insurance claim. Because each insurance company has unique policies and forms, we recommend that you contact your insurance company for instructions on how to submit your claim.

I understand that payment is due in full at time of service for all services. I understand that I will be billed for any appointments that I cancel with less than 24 hours notice, and for all missed appointments.

PATIENT SIGNATURE (or guardian signature)

DATE

WITNESS

Maryland Laser, Skin, and Vein Institute, LLC

*Robert A. Weiss, M.D. * Margaret A. Weiss, M.D. * Karen L. Beasley, M.D.*
54 Scott Adam Road, Suite 301 Hunt Valley, MD 21030 * Ph (410) 666-3960 Fx (410) 666-3981 * www.mdlsv.com

Cancellation, Missed Appointment, and Deposit Policies

Please realize that with all appointments, we have reserved time on our schedule especially for you. When an appointment is cancelled with late notice, or missed entirely, this time can not be used for anyone else. Therefore, we require that at least 24 hours notice be given for cancellation of all appointments. If an appointment is cancelled with less than 24 hours notice, or if an appointment time is missed altogether, a fee will be assessed for this cancelled/missed appointment. Additionally, a deposit may be required to reserve a future appointment.

Saturday appointments

A \$75 deposit is required to reserve a Saturday appointment, which will be applied in full to the treatment provided the appointment is kept. If the appointment is cancelled with more than 24 hours notice, the deposit will be credited to your account for a future appointment, or refunded if you choose. If the appointment is cancelled with less than 24 hours notice, or if the appointment time is missed, the \$75 deposit will be retained as a cancellation/missed appointment fee.

Appointments greater than 50 minutes

Due to the significant amount of time reserved for particular treatments, a deposit of \$100 is required at the time of scheduling to reserve an appointment over 50 minutes. This deposit will be applied in full to the treatment provided the appointment is kept. If the appointment is cancelled with more than 24 hours notice, the deposit will be credited to your account for a future appointment, or refunded if you choose. If the appointment is cancelled with less than 24 hours notice, or if the appointment time is missed, the \$100 deposit will be retained as a cancellation/missed appointment fee.

Treatments > \$1,000.00

Certain higher-cost procedures that require preparation on the part of the physician and staff will require a deposit to reserve treatment time. This deposit will equal 50% of the proposed cost of treatment. This deposit will be applied in full to the treatment, provided the appointment is kept. If the appointment is cancelled with more than 24 hours notice, the deposit will be credited to your account for a future appointment, or refunded if you choose. If the appointment is cancelled with less than 24 hours notice, or if the appointment time is missed, \$100 will be retained as a cancellation/missed appointment fee. The balance will be credited towards future treatment.

Vein surgery and Liposuction

A 50% deposit is required at time of scheduling a surgical procedure. If you cancel or reschedule your surgery with more than 2 weeks notice, you will receive full credit or refund of your deposit. If you cancel your surgery with less than 2 weeks notice, 20% of the cost of the total surgery will be retained as a cancellation fee. If you miss your appointment altogether, the 50% deposit will be retained in full as a missed appointment fee.

Thermage

A 50% deposit is required at time of scheduling a Thermage treatment. If you cancel or reschedule your Thermage with more than 1 week notice, you will receive full credit or refund of your deposit. If you cancel your Thermage with less than 1 week notice, 20% of the cost of the total treatment fee will be retained as a cancellation fee. If you miss your appointment altogether, the 50% deposit will be retained in full as a missed appointment fee.

Laser Hair Removal

Laser hair removal services are provided by licensed Nurse Practitioners and Physicians Assistants at MDLSV. The consultation and test area fee for laser hair removal is \$100, and is due at the time of scheduling. This consultation fee will be applied to your first full treatment. If it is determined that you are not a candidate for laser hair removal, your \$100 will be refunded in full. If you cancel your consultation with less than 24 hours notice, or if you miss your appointment altogether, the \$100 consult fee will be retained as a cancellation/missed appointment fee. A \$100 deposit will be required in order to make future appointments.

Tattoo removal

Tattoo removal services are provided by licensed Nurse Practitioners and Physicians Assistants at MDLSV. The consultation and test area fee for tattoo removal is \$175, and is due at the time of scheduling. If it is determined that you are not a candidate for tattoo removal, your deposit will be refunded in full. If you cancel your consultation with less than 24 hours notice, or if you miss your appointment altogether, the \$175 consult fee will be retained as a cancellation/missed appointment fee. All regularly scheduled treatment sessions must be secured by making a \$100 deposit on your account before beginning a course of treatment. If an appointment is missed or cancelled on late notice, this \$100 deposit will be applied as a cancelled/missed appointment fee. A new deposit of \$100 will be required to secure your next appointment. At the conclusion of treatment, any deposit remaining on your account will be refunded to you.

NOTICE OF PRIVACY PRACTICES

This practice has implemented the following policies and procedures to ensure the confidentiality of your personal and/or medical information. Federal and state laws require us, to maintain the privacy of your health information.

Your physician(s) and all other employees working in the practice will keep any information related to you (medical and/or non-medical) in a confidential manner. However, so that we may provide you with appropriate medical care, for general practice operations and or for the purposes of obtaining payment, we will, at our discretion provide information pertaining to the treatment you received in this practice, the charges for this treatment and related information regarding the treatment and charges to other health care related entities. This information will be submitted through the following mechanisms: US Postal Service, fax submission, Internet submission, voice mail and/or personal communications. The following is a list of the most common types of entities that we most typically would provide personal health related information. This list is not an all-inclusive list. Other entities may be added to this list.

- Physicians and non-physician providers (i.e. physician therapist, nutritional counselors) who work outside of this practice.
- Medical facilities (i.e. hospitals, outpatient centers).
- Laboratories for the purposes of running medical tests.
- Other health care providers, such as pharmacies, durable medical equipment suppliers, ambulance services.
- School health departments.
- Insurance companies (or third party administrators) for the purpose of obtaining payments, reviewing medical necessity and or general case management.
- State or Federal agencies that require the submission of specific health related information.
- Billing services.

We may need to **contact you, by written correspondence mailed to your residence or by phone**, to deal with matters related to your appointments, test results, treatments, referrals, account balance and/or to return your phone call. We will first attempt to contact you at home, however if you are not available and you provide us with your work number, we will attempt to contact you at work. If you are not available, we will leave a message for you to either call the office for a specified reason (i.e. discuss test results, account balance) or we will remind you of your appointment time.

In the event you do not pay all of your charges in full at the time of your visit, we **will mail** a statement to your home. Also, depending upon your situation, we may mail recall cards to your home noting that you need to contact the office to schedule an appointment. Periodically, we may mail test result information to your home. We will use the home address you provided us with at the time you register with the practice.

We may contact your insurance company to determine your coverage, eligibility, unmet deductible and/or your co-insurance and co-pay requirements. If necessary for obtaining payment, we will provide credit bureaus and/or collection agencies with your account information.

When you arrive at our practice for your appointment, we will ask you to sign in and note your arrival time. We will do our very best to see you promptly. However, there may be times when your provider is running behind schedule and you will need to wait in the waiting room.

You must provide written authorization for the release of information to entities such as a life or disability insurer or for the purpose of transferring your record to another physician or medical facility. At your request, we will send you the necessary form to complete for this authorization.

You may review and/or obtain a copy of your medical record. You may request, in writing, changes be made to your medical record. We will review your reason(s) for such a request and if we agree, will make the change(s). If we do not agree with your request, you are entitled to have your statement added to the record. Also, you may request information regarding who we have disclosed your medical information to for purposes other than treatment, payment and health care operations.

Please provide us with current information regarding your phone numbers (work and home) and home billing address. This will allow us to make the correct contact when trying to reach you.

When necessary these policies will be modified to ensure compliance with practice operations and with State and Federal privacy regulations.

If you have any questions or concerns with the policies and/or procedures noted above, please contact our practice manager at the above address and phone number to report any and all concerns. We trust that you are comfortable with our sincere efforts to maintain the confidentiality of the information related to your medical care. You may revoke any aspects of this consent at any time by giving us written notice. Finally, if you believe we have not maintained the privacy of your records, you may file a complaint with the Secretary of the US Dept. of Health & Human Services. There will be no retaliation for filing a complaint.

I _____ acknowledge the receipt of these policies relevant to the information in my medical record. Effective Date: _____

Signature: _____ (Seal) Date: _____ Witness: _____ 4-10-03 O-114

**PLEASE ADVISE US IF YOUR INSURANCE REQUIRES
US TO USE A SPECIFIC LAB.**

To Our Patients:

Pathological Examination of All Surgical Specimens

All tissue specimens that are surgically removed in this office are sent for pathological examination under the microscope. This is done to verify the diagnosis that is suspected clinically, and to insure that appropriate treatment has been given.

The bill for this pathological examination is separate and distinct from the surgical fee. Notification often arrives later than that relating to the surgery itself, and comes from either our office or from another Dermatopathology laboratory. If complete insurance information has been given to us, your insurance company will be billed for this service. If the insurance does not cover this, you will be responsible for its payment. If you have any questions regarding the pathological examination of lesions, or it's billing, please ask us at the front desk.

Lab Work

All blood/cultures taken in this office are sent to a laboratory for testing. The bill for this lab work is separate and distinct from the office visit charge. Notification often arrives later and comes from the laboratory who did your work-up. If complete insurance information has been given to us, your insurance company will be billed for this service. If the insurance does not cover this, you will be responsible for payment. If you have any questions, please ask us at the front desk.

I have read the following information and understand its content.

Patients Signature

Date

- Diplomats, American Board of Dermatology • Fellows, American Academy of Dermatology •
 - Fellows, American Society for Dermatologic Surgery •
- Fellow, American College of Mohs Micrographic Surgery and Cutaneous Oncology •