



Today's Date: _____

Patient Name: _____ Age: _____ D.O.B.: _____

Address: _____

City/State _____ Zip Code: _____

Sex M / F _____ Home Phone: _____ Work Phone: _____ Cell: _____

Email: _____ SSN: _____

Occupation: _____ Employer: _____ Marital Status: _____

In Case of an Emergency: _____ Phone: _____

Financial Information

Name: _____ SSN: _____

Relationship to Patient: _____ Home Phone: _____

Address (if different from above): _____

Insurance Information

Insurance Company _____

Name of Insured _____ Insured's D.O.B. _____

Insured's SSN: _____ Relationship to Patient: _____

Insured I.D.#: _____ Group #: _____

Secondary Insurance: _____

I.D.#: _____ Group#: _____

Name of Referring Physician or Person _____

Consent for Photo

I authorize Dr. Finkelstein and his staff to photograph me for the purpose of identification in my electronic medical records. Every effort will be made to protect the patient's identity in these procedures. Photographs are the property of *The Center for Skin Wellness*.

Signature: _____

Consent for Treatment

I give my permission for Dr. Finkelstein and his staff to treat me. I will follow the doctor's orders and use the prescriptions as indicated. I understand that medical care requires my cooperation. I will make and keep my medical appointments or call the office within 24 hours of cancellation to reschedule.

Signature: _____ Date: _____



**THE CENTER FOR SKIN WELLNESS - DR. ROBERT FINKELSTEIN
HEALTH HISTORY**

Here at The Center for Skin Wellness, we believe a person's overall health and wellness can have a big impact on the health and appearance of their skin. That's why we take an integrative approach to skin care. We like to know as much as we can about your skin care regimen, daily activities and approach to nutrition, so that we can treat your skin most effectively. We believe a whole-body approach results in the healthiest, best-looking skin possible.

Please take a few minutes to give us some background information on yourself so that we may SERVE you better. Thank you

PATIENT NAME: _____ D.O.B _____

How did you hear about us? _____

Who is your primary care physician? _____

Reason for today's visit? _____

Please check any of the following conditions you have:

Asthma _____ Actinic Keratosis (pre-cancers) _____ Bleeding Problems _____

Bowel Disease _____ Cancer/Type _____ Cardiac _____ Depression _____

Diabetes _____ Gout _____ GYN Problems _____ Heart Valve _____ Herpes Simplex _____

High Blood Pressure _____ High Cholesterol _____ Melanoma _____ Pace Maker _____

Skin Cancer/Type _____ Stroke _____ Thyroid _____

Please list any allergies: _____

Please list any past surgeries: _____

Other medical/skin conditions not listed: _____

Family's Medical History: _____

List current medications, vitamins & supplements: _____

Do you smoke? _____ How much per day? _____ For how many years? _____

Do you drink alcohol? _____ How much per week? _____



Do you currently have a skincare regimen? If so, please describe and include types of skin-care products:

Please circle any health issues and/or procedures of interest to you:

Botox Cosmetic	Skin Care / Products
Excessive Sweating (Hyperhidrosis)	Liver spots / Age spots
Facial fillers/ Lip enhancement	Facial / Leg veins
Acne	Sun Damage/Photoaging
Chemical Peels	Laser Treatments / Hair Removal
Micro Dermabrasion	Other? Please Specify_____

Would you like to speak with our Aesthetician regarding any of the above? YES / NO

Do you use sunscreen? If so, which statement best describes your usage?

- A. You'd think I was a lifeguard I have so much on every day_____
- B. I put it on in the morning and that's it for the day_____
- C. I usually remember to put it on my face but not the rest of me_____
- D. I usually put it on my body but often forget my face_____
- E. But don't remember to do it every day_____
- F. Only when I know I'll be outside for a long time_____
- G. I know I should, but I usually forget_____
- H. Since you are a dermatologist, I'd like to tell you I do, but I'd be lying_____
- I. I just don't use the stuff_____



Important Summary Notice of the Privacy of your Health Information

Your privacy is important to us. We record information about you so that we may provide quality medical care. *The Center for Skin Wellness* is committed to protecting this information. The notice of Privacy Practices describes your rights with regard to your health information and how we must protect the confidentiality of that information. This is a summary of the more detailed information contained in our Notice of Privacy Practices.

Your rights include:

- A right to amend your health information.
- A right to request restrictions on what information we use or how we discuss your health information.
- A right to see an accounting of certain disclosures we have made about you.
- A right to obtain access to your health information with limited exceptions (a written, notarized request, an appointment for access, and a cost-based fee for expenses is delineated by law).
- A right to receive a paper copy of our Notice of Privacy Practices.

We may use your health information and/or records to:

- Plan for your care and help your healthcare providers communicate and work together for you.
- Submit bills to pay for your care.
- Help healthcare payers or medical insurance companies ensure services provided.
- Disclose information to certain officials or organizations as required by law.
- Help improve the quality of your healthcare.

Everyone in our office who has access to your information is trained and bound by a confidentiality requirement and signs an agreement. Besides you, is there another person we may speak to about your health care and lab results? YES / NO

If yes, Name: _____ Phone: _____

I understand that I can view or request a copy of the Notice of Privacy Practices at the Center for Skin Wellness and the office of Robert Finkelstein D.O. (Copy is at reception desk)

Signature: _____ Date: _____



PAYMENT POLICY
PLEASE READ CAREFULLY

Co-payments, deductibles, and co-insurance amounts must be paid at the time of service.

Some plans require only your co-payment amount for office visits, but most have a deductible or co-insurance that applies to any procedures performed in the office. Only your insurance plan can verify that information for you.

If you are not able to pay your co-pay, and your visit is not an emergency, you may be asked to reschedule or call back with a credit card number by the end of the day. If you are not sure what your co-pay is, we will collect \$30.00 and bill or refund the difference promptly.

If you are not prepared to pay a deductible for a procedure you are having today, please let the doctor or nurse know that you need to schedule for a different day. If you are not sure what your deductible is, we will still need to collect an estimated amount and bill or refund the difference promptly.

All payments are due in full. We do not accept payment arrangements. However, we do accept CareCredit, which is a medical and cosmetic credit card that offers no-interest payments for 3, 6, 9, and 12 months, depending on the total. Please ask us for their website, brochure, or 1-800 number. You can get your account number within minutes and use it immediately.

***ACCOUNTS PAST 30 DAYS WILL BE CHARGED A LATE PAYMENT FEE OF 1.50% PER MONTH**
***ACCOUNTS PAST 90 DAYS MAY BE TURNED OVER TO OUR COLLECTION AGENCY WITHOUT FURTHER NOTICE.**

CANCELLATION & NO SHOW POLICY

We reserve the right to charge **\$25.00** for appointments missed (no shows), or canceled with less than 24 business hours' notice. Patients not canceling within 24 business hours for cosmetic or surgical procedure appointments will be charged **\$50.00**. Dr. Finkelstein understands "life" sometimes doesn't permit a 24-hour notice. This policy helps us protect the integrity of the schedule. We believe in a partnership to maintain good healthcare and overall wellness.

I hereby certify that I have read the consent and understand the contents:

Patient's Signature _____

Insurance Authorization

I authorize and request that my insurance company, in lieu of reimbursing me directly, pay Dr. Finkelstein any benefits for services rendered. I understand that my medical insurance carrier may pay less than the actual bill for services, and that I may be responsible for payment on behalf of my dependants. I understand that an outside lab may send a bill for work done in this office if my insurance company does not have a contracted lab or facility.

I authorize Dr. Finkelstein to release my information regarding exam, diagnosis and treatment rendered to me or my dependants during the period of medical care to third-party payers, including Medicare.

Patient's Signature _____ Date _____