The physicians and staff of New England Dermatology & Laser Center value and appreciate your selection of our office for your skin care. We are committed to providing you with the best possible service. A clear understanding of our office policy is important to our professional relationship.

INSURANCE AND MANAGED CARE

We participate in most insurance plans. Please inquire upon check-in to see if we accept your plan to avoid billing problems later. If your insurance plan requires a referral, you must have a valid referral on file from your primary care physician. If your visit has not been authorized, you have the option of signing a waiver making you financially responsible for that visit or rescheduling your appointment until such time as your visit is authorized.

APPOINTMENT CANCELING POLICY

We kindly ask for 24 hours notice if you cannot keep your scheduled appointment so that we may fill that opening. We reserve the right to charge a $25.00 Missed Appointment fee if you do not cancel within that time frame.

Please initial _____.

COSMETIC REMOVAL OF BENIGN LESIONS

A benign lesion is a spot or growth which in the physician’s opinion is not cancerous or pre-cancerous and for which there is no medical reason to treat. Insurance companies will pay for the evaluation of these lesions, but will not pay for their removal. Lesions which may fall into this category include: certain moles, brown spots (so called “liver” or “age” spots), angiomas (blood vessel moles and “broken” blood vessels), seborrheic keratoses (warty moles), skin tags (small flaps of skin found around eyelids, neck, under arms, under breasts, and in groin), and milia (persistent whiteheads) on face and eyelids. If you have a benign growth which you would like to have removed, you must sign a “waiver of liability” agreeing to be personally and financially responsible and payment is expected at the time of treatment.

If you have any questions, please feel free to inquire before signing below.

I have read and understand the above policies.

Patient signature ____________________________ Date ______________

Guarantor signature (if guarantor is not the patient) ____________________________ Date ______________
Name: ________________________________
Date of Birth: _______________________
Chart: ______________________________
Date: ________________________________

**Patient Authorization for Treatment, Payment & Photographs**

**ALL PATIENTS:**
- I hereby authorize medical/surgical treatment, care and/or services by New England Dermatology & Laser Center and authorize payment directly to New England Dermatology & Laser Center for all medical/surgical benefits, if any, that may be payable to me under the terms of my health insurance policy. I fully understand that I am primarily and financially responsible for fees incurred and that payment to New England Dermatology & Laser Center is not contingent on any settlement, judgment, or verdict by which I eventually recover medical fees.
- I hereby consent to and authorize New England Dermatology & Laser Center to use and disclose any of my health information, including my medical records and prescription medical history, for purposes concerning my treatment, payment for health care provided to me or the health care operations of New England Dermatology & Laser Center or other treating health care provider or plan.

Signature of patient or guardian _____________________________________________ Date ______________

**PHOTOGRAPHS:**
I give New England Dermatology & Laser Center permission to take clinical photographs for my medical record. I understand that the photographs remain the property of the office and may be used anonymously for the purpose of furthering medical education.

Signature of patient or guardian:______________________________________________

**Acknowledgement of Receipt of Notice of Privacy Practices**

It is the policy of New England Dermatology & Laser Center to provide all patients, or their parents, guardians or personal representatives, a copy of our current Notice of Privacy Practices prior to the date of the first service delivery, or upon the first visit to New England Dermatology & Laser Center after April 14, 2003, if feasible. This signed acknowledgement is to be filed in the medical record.

**I have received New England Dermatology & Laser Center's Notice of Privacy Practices**

Signature of patient or guardian _____________________________________________ Date ______________

**Authorization to Disclose Protected Health Information to family, friends, and/or others**

By signing below, I have authorized New England Dermatology & Laser Center to disclose my Personal Health Information to the following family or others:

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<th>Name</th>
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Please complete YOUR personal contact information below:

Home Phone: ___________________________ May we leave a message on your answering machine? ________
Work Phone: ___________________________ May we leave a message on your answering machine? ________
Cell Phone: ___________________________ May we leave a message or auto message on your VM? ________
E-mail: ______________________________ May we email a message to you? ______________

You are required to state how long this consent is valid for: ______ one year ______ two years ______ three years

You may revoke this authorization at any time by stating in writing to our Privacy Officer.

Patient or guardian signature: _____________________________________________ Date: ______________
REVIEW OF SYSTEMS

Who is your Primary Care Physician? ______________________________________________________________

Have you ever been a patient in our office? Yes No If yes, how long ago? _________________________________

What WAS the reason? ____________________________________________________________________________

What IS the reason for your visit today? __________________________________________________________________

Are you ALLERGIC or have you had ADVERSE REACTIONS to any MEDICATIONS, FOODS, LATEX OR RUBBER, or other products? Yes No If yes, please list and explain. ______________________________________________________

List ALL MEDICATIONS, PRESCRIPTIONS, and/or NON-PRESCRIPTION drugs (including herbal medications, aspirin, birth control pills, hormones, allergy shots, vitamin, laxatives, pills for headache, arthritis, nerves, sleeping, pain, etc.) that you take daily. _____ No Medications __________________________________________________________

Please CIRCLE any of the following MEDICAL PROBLEMS you have or have had. List any others.

HEART: High blood pressure, angina, heart attack, heart murmur, irregular heart beat, pacemaker
LUNG: Bronchitis, emphysema
STOMACH, BOWEL or LIVER: Ulcers, colitis, diverticulitis, irritable bowel
KIDNEY DISEASE:
GYNECOLOGICAL: Irregular menstrual cycles
METABOLIC: Diabetes, thyroid
NEUROLOGIC: Migraine headaches, convulsions, stroke
MENTAL HEALTH COUNSELING: Was medication prescribed? _____ Yes _____ No
BLOOD: Bleeding, anemia
ARTHRITIS: Rheumatoid, osteoarthritis, psoriatic, lupus
BONE/JOINT IMPLANTS: Artificial knee, hip, metal pins, etc.
VASCULAR: Varicose veins or blood clots in legs
EYES: Glasses, contact lenses, glaucoma, cataracts, lens implants
EARS: Hearing aid
ALLERGIES: Asthma, hay fever, sinus, hives
INFECTIOUS DISEASES: Hepatitis, Tuberculosis, HIV, other
CANCER: Type: __________________________________________

Treatment: Radiation Chemotherapy Year of Treatment: ____________________________

List Surgery & Year of Treatment: ______________________________________________

OTHER DISEASES: _________________________________________________________________
Are you pregnant or could you be pregnant?  Yes  No

After injury or surgery, have your scars healed satisfactorily?  Yes  No

Have you or any family members had bleeding problems with dental procedures or surgery?  Yes  No

Have you ever had a reaction to locally injected anesthesia (Novocaine/Xylocaine) similar to that which you may receive at the dentist?  If yes, please explain: ________________________________  Yes  No

Have you had skin reactions to band aids, adhesive tape, antibiotic ointments or topical creams?  Yes  No

Have you ever fainted? If yes, what were the circumstances? ______________________________  Yes  No

Prior to dental procedures or surgery, have you been advised to take antibiotics because of a heart problem, artificial joint implant or other reason?  Yes  No

Please circle skin type:  I  Always burn, never tan
                     II  Always burn, but sometimes tan
                     III  Sometimes burn, but sometimes tan
                     IV  Never burn, always tan  

Please CHECK any skin problems you HAVE or have HAD:

Eczema  Warts  __________
Psoriasis  Growth removed  __________
Cold sores  Skin cancer/melanoma  __________
Frost bite  Other:  __________

Have your brothers, sisters or parents had any of the following? Please CHECK:

Asthma, hay fever, sinus problems, hives  Frostbite  __________
Eczema  Warts  __________
Psoriasis  Skin cancer/melanoma  __________
Severe acne  Other:  __________

Do you smoke?  Yes  No
Do you drink alcohol?  Yes  No

Occupation:

PATIENT SIGNATURE: ______________________________________________________________________

For office use:  Reviewed with the patient.  By ____________________ and/or ____________________
New England Dermatology & Laser Center
Meaningful Use Patient Registration Form

In compliance with the HITECH Act to attain Meaningful Use, we are required to obtain certain demographic information. This is an important part of your medical history and required for our clinical quality improvement measures. Please complete the information below.

Patient: _______________________________  D.O. B. __________  MR #: __________

Email: _______________________________  ☐ No Email

Language:  ☐ Declined Language  ☐ English  ☐ French  ☐ Hindi  ☐ Italian  ☐ Spanish
Race:  ☐ Declined Race  ☐ American Indian/Alaska Native  ☐ Asian  ☐ Black or African American  ☐ Native Hawaiian or Pacific Islands
Ethnicity:  ☐ Declined Ethnicity  ☐ Non Hispanic or Latino  ☐ Hispanic or Latino

Tobacco Use:

☐ Never smoker  ☐ Current every day smoker  ☐ Current some days smoker  ☐ Heavy smoker  ☐ Light smoker

☐ Smoker; current status unknown  ☐ Former smoker  If smoking; number of packs per day: ______

Date started smoking: __________________  Date stopped smoking: __________________

☐ I allow New England Dermatology & Laser Center to access my prescription medication history from healthcare providers or pharmacies for treatment purposes.

☐ I will not allow New England Dermatology to access my prescription medication history allowing them to prescribe appropriately.

Patient or guardian signature: __________________________  Date: __________________