Total Skin and Beauty Dermatology Center, P.C. will be sending e-mails to those patients wishing to participate. Topics will include updates on:

- Appointment Reminders
- New procedures being offered at our practice
- New research protocols that are recruiting patients
- Periodic newsletters
- Special offers and discounts
- Educational opportunities

Your e-mail address will not be shared with any other party. No other recipient of the e-mail will have or gain access to your e-mail address. If you wish to unsubscribe at any time, please follow the instructions at the bottom of the e-mail or contact our office. This e-mail system is not secure and was not designed to convey sensitive information.

___ Yes, I would like to subscribe to Total Skin and Beauty Dermatology Center's E-mail Notification System. My e-mail address is:

(please print)

Patient Signature ___________________________ Date ________

For internal use only:

Date entered into system: ___________________ Date removed: ___________________
Initials: ___________________ Initials: ________________
TOTAL SKIN AND BEAUTY DERMATOLOGY CENTER
PATIENT CONTACT INFORMATION SHEET

Patient Legal Name: ________________________________

Account Number: ________________________________

Any physician, staff, employee or representative of TOTAL SKIN AND BEAUTY DERMATOLOGY CENTER has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone #</th>
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<tbody>
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PATIENTS SIGNATURE: ____________________________________________

DATE: __________________

OR

I do not want anyone to have access to my protected health information unless I provide explicit authorization.

PATIENTS SIGNATURE: ___________ DATE: ___________

**If any of this information changes, please let us know so we can update this form.**
Consent for Treatment/Financial Agreement: I consent to treatment necessary or desirable to the care of the patient first mentioned above, including but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designate. I also acknowledge full responsibility for the payment of all services, and agree to pay all amounts due in full at the time of service. I understand that the patient or responsible party is solely responsible for payment of all services, though the insurance may be filed. If this account becomes delinquent, I agree to pay all costs of collection, including reasonable collection agency fees currently 24% and attorney's fees. I understand that I will be charged for any returned check.

I understand that if my insurance is Medicare, Blue Cross Blue Shield (PMD), Blue Cross HMO or any plan such as Health Springs, Viva, United Healthcare, Aetna, Cigna, Secure Horizons, that some services are not always covered. These plans cover services based on medical necessity. Injections, intralesional injections, hair loss treatment, keloid removal/treatment, wart removal/treatment, skin tags, calveus (corns) removal/treatment and other skin lesions are not always considered medically necessary on these insurance plans. I understand that if any treatment is rejected by my insurance plan as a non-covered procedure that I will be billed for those services. I also acknowledge as a member of these plans, that this office will submit my insurance and I will be responsible for paying all copays and/or deductibles at the time of visit as well as any cosmetic treatment.

I understand that if my insurance is an HMO that I must obtain a referral from my Primary Care Physician every visit before coming to this office for any appointment. I understand that it is my responsibility as the patient to confirm that my referral is current and in effect before I arrive for my appointment. If no referral is obtained, I will pay for the visit.

I understand I will incur a $20.00 billing fee if my copayment is not paid at the time of my visit.

I authorize my insurance company to remit payment of medical benefits direct to this office for services provided by our physicians.

I hereby authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as all records necessary for the processing of insurance claims.

Patient Signature: __________________________________________ Date: ____________________

______________________________
Signature of Parent or Guardian (Child under 19 years old)
ADDITIONAL INFORMATION:

E-Prescribing Consent Form

ePrescribing is defined as a physician’s ability to electronically send accurate, error free, and understandable prescriptions directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribing program. These include:

- Formulary and benefit transactions- gives the prescriber information about which drugs are covered by the drug benefit plan
- Medication history transactions- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notifications- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient’s prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing the Total Skin & Beauty Dermatology Center, P.C. may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Total Skin & Beauty Dermatology Center, P.C. to enroll me in the ePrescription program. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient Name Printed

Patient DOB

Signature of Patient or Guardian

Date

Relationship to Patient
Patient Name:

Account Number:

PHARMACY INFORMATION:

Preferred pharmacy name

Phone#

City or Zip Code

At Total Skin and Beauty, we offer an in-house pharmacy. We understand that your time is valuable and we are happy to offer you this alternative so that you can get your dermatology care and prescriptions all in one place. The pharmacy is located on the first floor. If you would like to designate Total Skin and Beauty Pharmacy as your default pharmacy for e-prescribed medications, please check below:

☑ Set Total Skin and Beauty Pharmacy as my default pharmacy

MISC. PATIENT DATA:

Preferred Language:

Race: Ethnic Group:

Primary Care Physician:

Referring Physician:
TOTAL SKIN & BEAUTY DERMATOLOGY CENTER
History and Intake Form

Past Medical History: (please circle all that apply)

- Anxiety
- Arthritis
- Asthma
- Atrial fibrillation
- Bone Marrow - Transplantation
- BPH
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- NONE

Other

Past Surgical History: (please circle all that apply)

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Mastectomy (Right, Left, Bilateral)
- Breast: Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Breast Reduction
- Breast Implants
- Colon: Colectomy: Colon Cancer Resection
- Colon: Colectomy: Diverticulitis
- Colon: Colectomy: IBD
- Colon: Colostomy
- Gallbladder (Cholecystectomy)
- Heart: Biological Valve Replacement
- Heart: Coronary Artery Bypass
- Heart: Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA
- Joint Replacement, Knee (Right, Left, Bilateral)
- Joint Replacement, Hip (Right, Left, Bilateral)
- Joint Replacement within last 2 years
- Kidney Biopsy (Nephrectomy)
- Kidney Removed (Right, Left)
- Kidney: Kidney Stone Removal
- Kidney: Kidney Transplant
- Liver: Liver Transplant
- Liver: Shunt
- Ovaries: Oophorectomy: Endometriosis
- Ovaries: Oophorectomy: Cyst
- Ovaries: Oophorectomy: Ovarian Cancer
- Ovaries: Tubal Ligation
- Pancreas: Pancreatectomy
- Prostate (Prostatectomy) Prostate Biopsy
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): TURP
- Rectum: APR
- Rectum: Low Anterior Resection
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy): Fibroids
- Uterus (Hysterectomy): Uterine Cancer
- Uterus *Hysterectomy): Cervical Cancer
- NONE
Skin Disease History: (please circle all that apply)

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- NONE

Other

Do you wear Sunscreen?  Yes  No
If yes, what SPF?  
Do you tan in a tanning salon?  Yes  No

Do you have a family history of Melanoma?  Yes  No
If yes, which relative(s)?  

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Social History: (Please circle all that apply)

Cigarette Smoking:
- Currently Smokes
- Has smoked in the past
- Never smoked
- Former Smoker

Alcohol Use:
- EtOH- None
- EtOH- less than 1 drink per day
- EtOH -1-2 drinks per day
- EtOH -3 or more drinks per day

Other
Patient Name:

Account Number:

**Family History** (Only first degree relatives):

Review of Systems: Are you currently experiencing any of the following? (Please check yes or no for the following)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever, weight change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision or hearing change, ear pain, nasal congestion, throat pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest pain, palpitations, swelling in feet</td>
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<td></td>
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<tr>
<td>Shortness of breath, coughing</td>
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<td></td>
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<tr>
<td>Painful urination, urinary frequency, blood in urine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea, vomiting, diarrhea, blood in stool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint pain, stiffness or swelling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache, numbness, tingling</td>
<td></td>
<td></td>
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<tr>
<td>Depression, sleep changes</td>
<td></td>
<td></td>
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<tr>
<td>Skin cancer</td>
<td></td>
<td></td>
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<tr>
<td>Problems with healing or scarring</td>
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</tr>
</tbody>
</table>

Other Symptoms: __________________________________________________________

**ALERTS:** (please circle all that apply)

- Hepatitis C Positive
- Allergy to adhesive
- Allergy to lidocaine
- Allergy to topical antibiotics
- Artificial heart valve
- Artificial joint replacement
- Blood thinners
- Defibrillator
- MRSA
- Pacemaker
- Require antibiotics prior to a surgical procedure
- Rapid heartbeat with epinephrine
- Are you pregnant or currently trying to get pregnant?