Long Ridge Dermatology
1051 Long Ridge Road, Stamford, CT 06903
Tel: 203-329-7960 Fax: 203-329-7920 info@longridgedermatology.com

Cosmetic Interest Questionnaire

For many people, changes in physical appearance as we age can have a significant impact on self-confidence and even quality of life. Fortunately, today there are many options available to dramatically enhance and improve one's appearance, and reverse signs of aging.

Contact Information

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____Mobile phone: _____

Work phone: _____

E-mail address: _____

Please indicate your preferred method of contact: _____

By letting us know your concerns and preferences, we can help you decide which treatments will offer you the best results.

For the following statements, please circle the number that best reflects your opinion, with 1 as agreeing the least and 5 as agreeing the most.

1. If effective, non-surgical options were available to successfully correct my lines and wrinkles, I would be interested.

1 2 3 4 5

2. I would prefer correcting my wrinkles and lines with a product that does not contain animal-derived ingredients.

1 2 3 4 5

3. What cosmetic procedures, if any, have you had in the past?

4. If you have previously had any cosmetic procedures, were you pleased with the outcome?

   __Yes __No

   If no, in what way were you dissatisfied?

5. Sometimes the best results can be achieved through different products or procedures by using multiple products or procedures. Please let me/us know which of the following would interest you. Check all that apply.

__Dermal fillers such as *Restylane*®

__AHA and glycolic peels

__Skin rejuvenation

__Topical wrinkle treatments such as RENOVA®

__Microdermabrasion

__BOTOX® Cosmetic

__Acne treatment

__Chemical peels

__Laser resurfacing

__Laser treatments

—Skin-care advice

__Skin-care products

__Birthmark correction

__Liver spot/age spot correction

__Sunscreen advice

__Leg vein correction or removal

__Facials and hair treatments

__Hair removal

__Facial vein removal or correction

__Other (please specify): _____

6. If our office hosted an event to inform patients about cosmetic procedures, would you be interested in attending?

__Yes __No

If yes, may we contact you about these events?

__Yes __No

Signature_____

7. How did you hear about our practice?

__Physician

__Friend or family member

__Seminar

__Insurance company

__Internet

__Phone book

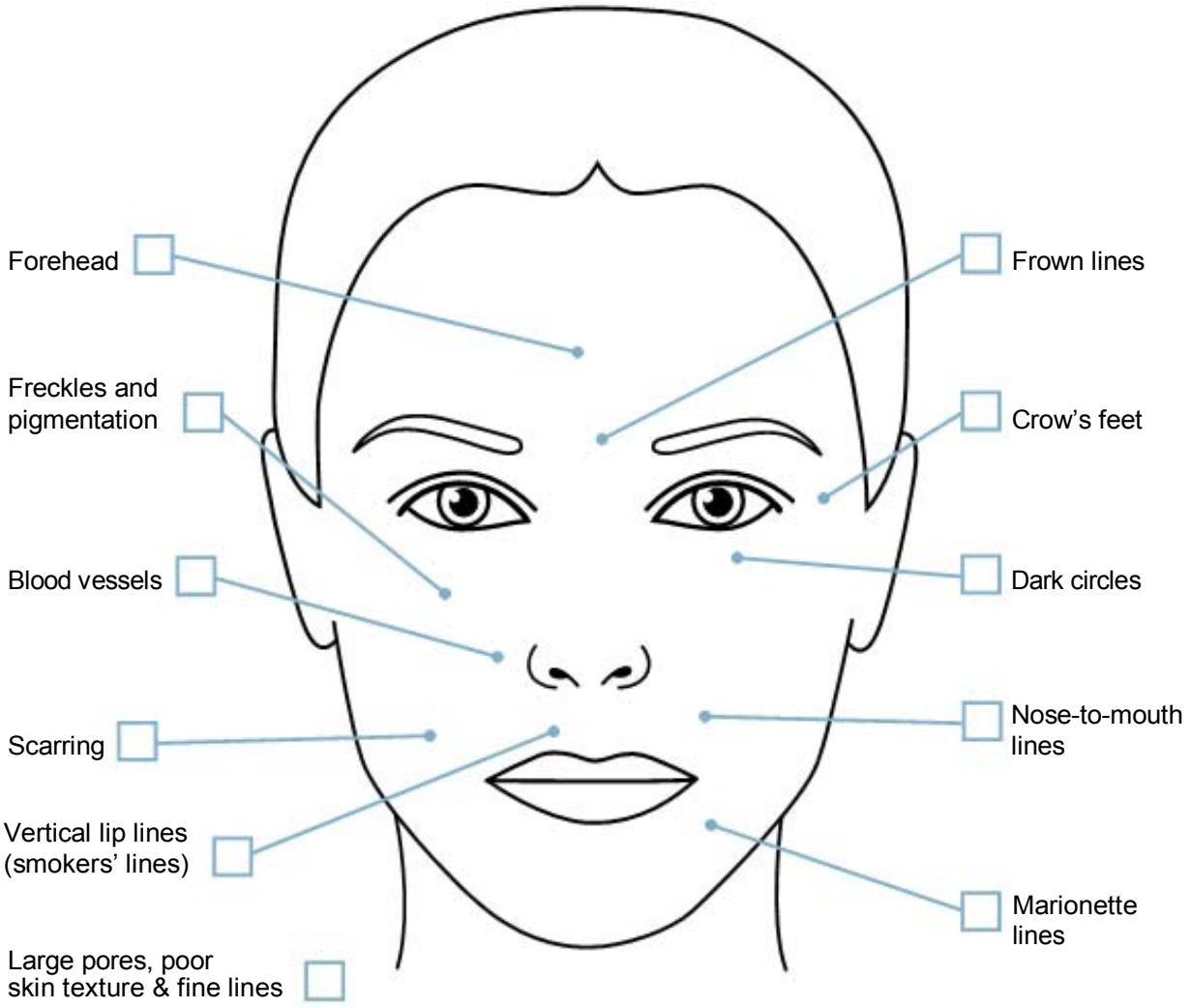
__Advertisement or article (please specify):

__Other (please specify):

8. If you were referred by one of our patients, please let us know the name so that we may thank him or her. _____

Thank You.

With respect to signs of aging, please highlight those areas of the face that bother or trouble you. In the box provided, please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome).



LONG RIDGE DERMATOLOGY, LLC
1051 LONG RIDGE ROAD
STAMFORD, CT 06903
(203) 329-7960

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____
Printed Name – Patient or Representative

_____
Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____
Printed Name – Practice Representative

_____
Signature Date

LONG RIDGE DERMATOLOGY

LONG RIDGE DERMATOLOGY, LLC
Medical History

Patient : _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ❒ YES ❒ NO If yes, list:

1. _____ 2. _____

List all Medications you are currently taking:

1. _____ 3. _____

2. _____ 4. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**	**Other Systemic:**	**YES**	**NO**
Bronchitis	❒	❒	Diabetes	❒	❒
Emphysema	❒	❒	Thyroid	❒	❒
Asthma	❒	❒	Kidney	❒	❒
Chronic Cough	❒	❒	Bladder	❒	❒
Morning Cough	❒	❒	Stomach	❒	❒
			Bowel	❒	❒
Vascular:			Hepatitis or Yellow Skin	❒	❒
High Blood Pressure	❒	❒	Glaucoma	❒	❒
Chest Pain	❒	❒	Arthritis/Joint Deformity	❒	❒
Heart Attack	❒	❒	Convulsions, Epilepsy		
Heart Murmur	❒	❒	or Seizures	❒	❒
Irregular Heart Beat	❒	❒	Fainting	❒	❒
Pacemaker	❒	❒			
Phlebitis	❒	❒			

Do you drink alcohol? ❒ YES ❒ NO If YES _____ drinks per day

Do you use IV drugs? ❒ YES ❒ NO If YES, what? _____ How much? _____

Have you had or have you been exposed to HIV(AIDS)? ❒ YES ❒ NO

Have you ever had dental anesthesia (Novacaine)? ❒ YES ❒ NO Any bad reaction? ❒ YES ❒ NO

Skin:

When you are exposed to sun do you: ❒ Tan only ❒ Tan and burn ❒ Burn

Have you ever had skin cancer? ❒ YES ❒ NO

Has anyone in your family had skin cancer? ❒ YES ❒ NO If YES, Who? _____

Do you have a history of any specific skin diseases? ❒ YES ❒ NO

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

A. Do you smoke? ❒ YES ❒ NO If yes, how much: _____

B. Do you bleed easily? ❒ YES ❒ NO

C. (Women) Are you pregnant? ❒ YES ❒ NO Due Date: _____

D. Do you have artificial joint(s)? ❒ YES ❒ NO

E. What is your occupation? _____

F. What are your hobbies? _____

Completed by: ❒ Patient

❒ Medical Assistant _____
Initials

_____
Signed by Physician Date

_____
Reviewed by Date

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OFFICE/FINANCIAL POLICY

All patients must complete our Patient Information form in its entirety before seeing the doctor. Post Office Boxes can be used as a mailing address, but we must have your actual home address. Failure to complete information requested will result in a cancellation of your treatment with us.

PAYMENT FOR ANY ELECTIVE/COSMETIC TREATMENT OR MANAGED CARE CO-PAYS ARE DUE AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

Insurance

Co-pay – Your co-pay will be collected prior to treatment. Any co-insurance amounts, deductibles due, or increase of your co-pay is your responsibility and we will balance bill you for these amounts, if applicable. **Self-Pay** – If we do not participate with your insurance company, payment in full is expected at the time of service. **Unpaid balance** – If your insurance company has not paid your account within 45 days, the balance will be automatically transferred to you. Every insurance contract is different and your insurance company makes the final determination regarding reimbursement for services rendered. If your insurance company advises us that your insurance policy has terminated or that there is a balance due, you will be billed. It is your responsibility to discuss any insurance problems directly with your insurance company. Balance is to be paid in full at the time the statement is issued. **Referrals** – If treatment by a specialist requires a referral from your insurance company, it is the patient's responsibility to obtain this referral *prior* to your arrival in this office. We will not be able to allow telephone calls to be made from our phones to obtain referrals.

Elective/Cosmetic Procedures

These include, and may not be limited to: Botox™ Injections, Chemical Peels, Skin Tag Removal, Dermapeels, Laser Hair Removal, Spider Vein Treatment, Facial Rejuvenation, keloid injections. Payment for these services is your responsibility and is due and payable *in full* at the time services are rendered.

Medicare Patients

We accept Medicare assignment. This means that the doctor receives 100% of the allowable charges for services rendered to you. If you do **not** have secondary insurance, the 20% of the allowable charge is due at the time of service, as well as any portion of your annual Medicare deductible that you have not satisfied for the current calendar year. If you do have secondary insurance, we will bill that insurance on your behalf after Medicare has processed our claim. You will be balanced billed for any amounts legally allowable and not reimbursed by your secondary insurance carrier.

Minor Patients

Treatment will not be rendered to anyone 17 years old or younger unless accompanied by a parent or guardian.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy is to charge $75.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Fees

We reserve the right to charge a $3 late fee PER MONTH to any unpaid balances over 30 days old. Insufficient funds fee is $25 on returned checks. Future payments on accounts that have had a check returned will be credit card only.

I have read, understand and agree to this POLICY.

_____ _____

Signature of patient or Responsible Party Date

LONG RIDGE
DERMATOLOGY

PATIENT REGISTRATION
LONG RIDGE DERMATOLOGY

Patient Name: _____ Today's Date: _____
(First Name) (Middle Initial) (Last Name)

Address: _____ Rep Initials: _____
(Street/PO Box) (City) (State) (Zip Code)

Home Phone: ( ) _____- _____ Work Phone: ( ) _____ - _____ Extension: (_____)

Emergency Phone: ( ) _____ - _____ Extension: (_____) Contact Name: _____
(First Name) (Last Name)

Birth Date: _____ / _____ / _____ Sex: M F Marital Status: S M D W S.S. # _____ - _____ - _____

Primary Care Phys: _____ Patient Employer: _____
(First Name) (Last Name)

Employer Address: _____
(Street/PO Box) (City) (State) (Zip Code)

Primary Insurance: _____ Group # _____ Policy/ID# _____

Address: _____
(Street/PO Box) (City) (State) (Zip Code)

Policy Holder Name: _____ Birth Date: _____ / _____ / _____ Sex: M F

Employed At: _____ Address: _____
(Name of Business) (Street/PO Box) (City) (State) (Zip Code)

Secondary Insurance : _____ Group # _____ Policy/ID# _____

Address: _____
(Street/PO Box) (City) (State) (Zip Code)

Policy Holder Name: _____ Birth Date: _____ / _____ / _____ Sex: M F

If this visit is in regard to a **WORKERS COMPENSATION INJURY** or **AUTOMOBILE ACCIDENT** please fill out this information in addition to the above:

Date of Injury: _____ / _____ / _____ Claim # _____ Insurance Co. Name: _____

Address: _____ Claims Adjustor: _____
(Street/PO Box) (City) (State) (Zip Code) (First Name) (Last Name)

Name of Attorney and Law Office/Contact at Employers office: _____

Phone # : ( ) _____ - _____

If in the event my case is not approved, I will be responsible for payment in full to the Physician. Signature _____

I, _____ DO HEREBY GIVE AUTHORIZATION FOR DIRECT PAYMENT TO LONG RIDGE DERMATOLOGY.
If in the event, services are rendered to me by a Physician or Physician's Assistant, not on my plan, I will be fully responsible for any and all charges incurred.
I understand and acknowledge that a paper copy of "Notice of Privacy" will be offered upon my request.

(Patient Signature) _____ (Date) _____