THE SKIN & WELLNESS CENTER

CONSENT FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Consent for Treatment

I consent to the provision of medical treatment, which may include but is not limited to: routine examination, diagnosis/diagnostic tests, and general treatment to be performed by The Skin & Wellness Center, PLLC (henceforth referred to TSWC) . I understand that TSWC will explain any examination or treatment, including the anticipated benefits, risks, and any available alternative therapies including receiving no treatment and that I may ask questions and have those questions answered, to the best of TSWC ability, regarding any such examination or treatment. I acknowledge that no guarantees or assurances have been provided to me as to the outcome of any examination or treatment I understand and acknowledge that qualified medical professionals who are not physicians may perform all or parts of any examinations or treatment and will only be performing tasks that are within their scope of practice. I understand that if further medical examinations, procedure(s) or surgery are required, I may need to sign specialized consents. I understand and acknowledge that notwithstanding this general consent to treatment, I have the right to refuse any treatment, examination, or procedure to the extent permitted by law.

Consent to the Use & Disclosure of Health Information for Treatment, Payment, Or Healthcare Operations

I authorize TSWC to use and disclose my protected health information in order to carry out treatment, payment, or healthcare operations. I acknowledge that I have been provided with TSWC Notice of Privacy Practices, which provides a complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent. I understand that TSWC reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office.

Financial Agreement

I authorized TSWC to bill my insurance carrier and that any payment of insurance benefits be made directly to TSWC. I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). This also applies if I am covered by Medicare, a HMO, or any other payer. I understand that it is my responsibility to verify with my insurance company if the provider is "in-network" to receive full insurance benefits. I certify that the information I provided related to my insurance coverage or other payment source(s) is correct.

I understand that self-pay accounts, co-payments, co-insurance, deductibles and non-covered services are required to be collected at the time of service. I understand that services which are normally covered may be denied in certain situations and I will be responsible for these balances. I understand that cosmetic procedures are not covered/paid by healthcare plans and I acknowledge that I am responsible for any balance due for such services.

Communication

I understand that TSWC may contact me by telephone (including mobile phone), and its affiliates and agents may use a pre-recorded / artificial voice message and/or an automated telephone dialing system, and/or by text message, and/ or email for any communication related to my account. By signing this document, I provide consent for our staff to leave messages via voice and/ or text and speak with family/household members regarding my care. I understand and acknowledge that such communication methods may not be secure.

This is a legal document. By signing, I agree that I understand and accept all terms on this form. I have the right to revoke the authorizations on this form at any time by notifying TSWC in writing, except to the extent that TSWC has already acted in reliance on them. I acknowledge and agree that such authorizations will remain valid until I revoke them in writing.

_____

Signature of Patient (or Authorized Representative) Date

_____

Printed Name of Patient (or Authorized Representative)

THE SKIN & WELLNESS CENTER

Name: _____ **Referring Physician:** _____

Date of Birth: _____ **Preferred Pharmacy:** _____

Past Medical History:

☐ Anxiety	☐ Diabetes	☐ Leukemia
☐ Arthritis	☐ End Stage Renal Disease	☐ Lung Cancer
☐ Asthma	☐ GERD	☐ Lymphoma
☐ Atrial Fibrillation	☐ Hearing Loss	☐ Prostate Cancer
☐ Bone Marrow Transplant	☐ Hepatitis	☐ Radiation Treatment
☐ Breast Cancer	☐ Hypertension	☐ Seizures
☐ Colon Cancer	☐ HIV/AIDS	☐ Stroke
☐ COPD	☐ Hypercholesterolemia	☐ NONE_____
☐ Coronary Artery Disease	☐ Hyperthyroidism	
☐ Depression	☐ Hypothyroidism	_____

Past Surgical History:

_____

_____

_____

_____

Medications:

_____

_____

_____

_____

Allergies:

_____

_____

Please See the Back of this Page to complete Form

Skin Disease History:

☐ Acne ☐ Actinic Keratosis ☐ Asthma ☐ Basal Cell Carcinoma ☐ Blistering Sunburns ☐ Dry Skin	☐ Dysplastic Nevi ☐ Eczema ☐ Flaking / Itching Scalp ☐ Hay Fever / Allergies ☐ Melanoma ☐ Poison Ivy	☐ Psoriasis ☐ Squamous Cell Carcinoma ☐ NONE ☐ Other: _____ _____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _____

Do you tan in a tanning salon ☐ Yes ☐ No

Review of Systems: Please select all that apply.

☐ **Rash**	☐ **Changing Moles**	☐ **Anxiety**	☐ **Pacemaker**
☐ **Immunosuppression**	☐ **Blurry Vision**	☐ **Depression**	☐ **Breastfeeding**
☐ **Chest pain**	☐ **Abdominal Pain**	☐ **Allergy to Adhesive**	☐ **Problems with Bleeding**
☐ **Fever/Chills**	☐ **Joint Aches**	☐ **Allergy to Lidocaine**	☐ **Problems with Healing**
☐ **Night Sweats**	☐ **Muscle Weakness**	☐ **Allergy to Topical Antibiotic Ointments**	☐ **Problems with Scarring**
☐ **Unintentional Weight Loss**	☐ **Headaches**		☐ **Pregnant/ or Planning Pregnancy**
☐ **Thyroid Problems**	☐ **Seizures**	☐ **Artificial Heart Valve**	☐ **Rapid Heartbeat with Epinephrine**
☐ **Sore Throat**	☐ **Cough**	☐ **Blood Thinners**	
☐ **Acne**	☐ **Shortness of Breath**	☐ **Defibrillator**	☐ **Premedication to Procedures**
☐ **Enlarged Lymph Nodes**	☐ **Wheezing**	☐ **MRSA**	

Family History:

Basal Cell Carcinoma: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son ☐ Uncle ☐ Aunt ☐ Nephew ☐ Niece ☐ Grandmother ☐ Grandfather ☐ Granddaughter ☐ Grandson

Breast Cancer: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son ☐ Uncle ☐ Aunt ☐ Nephew ☐ Niece ☐ Grandmother ☐ Grandfather ☐ Granddaughter ☐ Grandson

Melanoma: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son ☐ Uncle ☐ Aunt ☐ Nephew ☐ Niece ☐ Grandmother ☐ Grandfather ☐ Granddaughter ☐ Grandson

Squamous Cell Carcinoma: ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son ☐ Uncle ☐ Aunt ☐ Nephew ☐ Niece ☐ Grandmother ☐ Grandfather ☐ Granddaughter ☐ Grandson

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Patient Intake Form

Patient Information Date: _____

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Race / Ethnicity: _____ Language: _____

Email: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone Number: _____ Home Phone Number: _____

☐ Consent to Leave Detailed Voicemail

Emergency Contact Name: _____

Relationship: _____ Contacts Phone Number: _____

Reason For Visit, If Multiple Please Specify

_____

_____

Insurance (If self pay please leave blank)

Insurance Name: _____ ID: _____ Group: _____