Patient Demographic Form

Last Name: _____First Name: _____Middle_____

Address:_____ City: _____ State: _____Zip Code: _____

Telephone: Home: _____ Work: _____Cell: _____

Date of Birth: _____ Age:_____Sex: F__ M__ Email:_____

Race:_____ Ethnicity:_____ Preferred Language:_____

SS#: _____Employer:_____Occupation:_____

Spouse's Name: _____Phone:_____Date of Birth:_____

Emergency contact: _____Phone:_____Relationship:_____

Family Doctor Name/Address: _____Phone: _____

Pharmacy Name/Address: _____Phone: _____

How were you referred: ☐ TV INS ☐ YP RADIO FRIEND ☐ INTERNET ☐ OTHER _____

(DO NOT FILL OUT INSURANCE SECTION BELOW FOR WEIGHT LOSS OR AESTHETICS SERVICES)

INSURANCE INFORMATION

Primary:_____ Secondary:_____

Address:_____ Address:_____

Phone: _____ Phone:_____

ID#:_____Grp#_____ ID#:_____Grp#_____

Insured Name: _____DOB:_____ Insured Name: _____DOB:_____

NOTE: If your insurance requires a referral or authorization for office visits, it is your responsibility to obtain this prior to your visit.

ASSIGNMENT OF BENEFITS:
I hereby authorize payment directly to Understanding Women, Thomas Laser Center and Laser Surgery Center for all services rendered. I hereby authorize Understanding Women, Thomas Laser Center and/or Laser Surgery Center to release any information required to determine medical benefits payable for services to the organization, the Health Care Financing Administration my insurance carrier or other medical entity. I understand that I am financially responsible to the organization for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment.

Signed:_____Date_____

Financial Policy

Thank you for choosing our office. We welcome you! We are committed to providing the finest care and professionalism for our patients. Please carefully read and sign the following statement of our financial policy prior to treatment. Feel free to speak to our billing personnel if you have any questions.

The patient or their guarantor is responsible for payment of services that are rendered. If we are a preferred provider on your insurance plan, we will submit the claims to your insurance company and make every attempt to collect with the information that you provide. Please present your insurance card at each visit. **You will be responsible for all co-pay, coinsurance, and deductibles on the day of service.** Should an overpayment occur on the deductible or percentage amounts charged we would apply a credit to your account. A refund is available upon request. If a procedure is scheduled please be aware there will be a **Physician, Facility, Anesthesia and Lab fee**. We will submit for the Physician and Facility. If a procedure is generally deemed to be "cosmetic" or "non medically necessary", we do not bill insurance companies directly. You must pay for the procedure in full and we will provide you with the necessary paperwork to submit to your insurance company upon request.

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE BENEFITS.

You are ultimately responsible for payment of services rendered if your insurance carrier does not pay for any reason. If you are waiting for coverage to become effective or have no insurance, payment in full will be expected the day you are seen. For your convenience, we accept VISA, MC, Discover or cash.

All insurance information, including prior authorizations and referral forms, must be provided at the time of service and before you are seen. If information is not provided at the time of your appointment you will be rescheduled or considered self pay, your appointment will not be delayed while you obtain the information.

Delinquent accounts over 90 days will be subject to the following action. A collection-processing fee will be added to your outstanding balance and turned over to our collection agency Bureau of Medical Economics for further processing.

FEES: There will be a $40 fee for the following: Electronic copy of medical records to a patient or insurance company.

There will be a $50 service fee for all returned checks. NSF checks must be redeemed with certified funds (cashiers check, money order, certified check or cash).

If you need to cancel a scheduled appointment, please contact our office at least **72 business hours** before your appointment time. Because of high demand for appointments, missed appointments prevent us from scheduling appropriately and to care for others in need of urgent care. **A FEE WILL BE ASSESSED DEPENDING ON THE LEVEL OF COMPLEXITY FOR ALL MISSED APPOINTMENTS NOT CANCELLED WITH AT LEAST 72-BUSINESS HOURS ADVANCE NOTICE.**

REFUNDS FOR AESTHETIC SERVICES: All treatments (Single and/or packages) are Non-Refundable. Unused pre-paid treatments are not eligible for a refund but you may apply the credit toward future services or product.

PRODUCTS PURCHASES: Products are Non-Refundable or Exchangeable.

It is your responsibility to notify our office if there is a change in your insurance coverage, residence, or phone number.

I have read and I understand the Financial Policy and Notice of Privacy Practices and I agree to abide by its terms, a copy will be provided upon patient's request.

_____ _____ _____

Print Name Signature of responsible party Date

Patient Communication Authorization

Patient's Name: _____ Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It's okay to call:

_____ Home phone number Leave a message: __ yes __no

_____ Mobile/Cell number Leave a message: __ yes __no

_____ Work phone number Leave a message: __yes __no

_____ Call only this number. _____Leave a message: __yes __no

_____ Do not speak to family members.

I give permission to the individual(s) listed below to receive protected health information:

_____

_____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature_____ Date_____

MEDICAL HISTORY

Patient Name: _____Marital Status:_____ Age_____D.O.B:_____

Reason for today's visit:_____

DrugAllergies:_____

Are you allergic to Latex: __ Yes __No Hepatitis: __Yes __No HIV: __Yes __No

Past Medical History
__Hypertension
__Diabetes
__Long term steroid use
__ Seizures
__Heart disease
__Stroke
__Cancer
__Cholesterol disorder
__Thyroid disease
__Kidney disorder
__Bleeding disorder
__Lupus/Autoimmune Dis
__Gout
__Other_____
_____

Past Surgical History/Year
__Gallbladder _____
__Hemorrhoids _____
__Hysterectomy _____
__Heart Surgery _____
__Pace maker _____
__Defribulater _____
__Prostate _____
__Bowel Surgery _____
__Tubal ligation _____
__Thyroid Surgery _____
__C-section _____
__Bariatric Surgery _____
__Cosmetic(type)_____
__Other_____

Family History
__Heart Disease _____
__Breast Cancer _____
__GYN Cancer _____
__Blood clots in lungs or legs _____
__ Colon/Bower Cancer _____
__ Stroke _____
__ Prostate Cancer _____
__Other_____ _____
_____
_____
_____
_____
_____

Family Member (Immediate)

Current Medication/Vitamins Name/Dosage
__SEE LIST
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Social History:
__Other_____ Tobacco use: __Everyday __Some days __Former__ Never

Chief Complaint and Review of Systems
__Abdominal pain
__Anal itch
__Anal pain
__Anal warts
__Anemia
__Bladder control problems
__Breast mass/discharge
__Constipation
__Fatigue/tired/sluggish
__Heavy vaginal bleeding
__Hemorrhoids
__Menopausal symptoms
__Painful periods
__PMS
__Rectal bleeding
__Rectal drainage
__Screening Colonoscopy
__Unable to hold bowels
__Unable to hold gas
__Vaginal discharge
__Other_____
_____
_____

GYN History:
How many pregnancies: _____
Are you pregnant: _____
Do you plan to become pregnant: _____
Are you breast feeding: _____
Date of last:
Menstrual Period:_____
Pap Smear:_____
Abnormal Pap:_____Result: __normal __abnormal
Treatment: __burning __freezing __laser
Colonoscopy:_____Result: __normal __abnormal
Pelvic US:_____Result: __normal __abnormal
Endometrial Biopsy:_____Result: __normal __abnormal
Bone Density Scan:_____Result: __normal __abnormal
Mammogram:_____Result: __normal __abnormal

_____ _____
Signature Date

OFFICE USE ONLY

HT:_____ WT:_____ HGB:_____

BP:_____ P:_____ PREG TEST:_____