Advanced Medical & Cosmetic Center, LLC

Patient Information: (Please complete using your name as listed on your insurance card. **PRINT CLEARLY)**

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ SS#: _____ Sex: M F

Address: _____ Apt: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____

Marital Status: Single Married Divorced Domestic Partner Widow

Employer: _____ Occupation: _____

STUDENTS ONLY: (If over 18 years of age) Part-time student Full-time student

Under a new federal law, the following questions are now required:

- ☐ English
- ☐ Spanish
- ☐ Other _____
- ☐ I'd rather not report

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ I'd rather not report

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic Origin
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other _____
- ☐ I'd rather not report

Email Address: _____

Do you have any impairment? (Please circle): Visual Hearing Speech Learning Physical Language/Cultural NONE

Person Responsible for Payment:

First Name: _____ Initial: _____ Last Name: _____

Address: _____ Apt: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Relationship to patient: _____ Date of Birth: _____ SS#: _____

Insurance Information: (All patients must provide a copy of their insurance card and proper ID at **every** visit.)

Primary Insurance: _____ Policy Holder Name: _____

Policy ID#: _____ Group#: _____

Relationship to patient: _____ Policy Holder's Date of Birth: _____ Sex: M F

Policy Holder's Employer: _____

Secondary Insurance: _____ Policy Holder Name: _____

Policy ID#: _____ Group#: _____

Relationship to patient: _____ Policy Holder's Date of Birth: _____ Sex: M F

Policy Holder's Employer: _____

Who may we thank for referring you? _____

Pharmacy Name: _____ Town/Location: _____

Have you had any of the following conditions in the past?

Skin cancer	Y	N	Hepatitis/Liver disease	Y	N
Melanoma	Y	N	Lupus	Y	N
Atypical moles (dysplastic nevus)	Y	N	Herpes simplex	Y	N
Basal cell carcinoma	Y	N	Bleeding disorders	Y	N
Squamous cell carcinoma	Y	N	Crohn's/Colitis disease	Y	N
Actinic keratoses	Y	N	Heart valve replacement	Y	N
T-cell lymphoma	Y	N	Pacemaker	Y	N
Other cancer	Y	N	Hip replacement	Y	N
Diabetes	Y	N	Cataracts	Y	N
Sarcoid	Y	N	Glaucoma	Y	N
Heart disease	Y	N	Kidney/Renal disease	Y	N
Stroke/TIA	Y	N	GYN problems	Y	N
Seizures/Epilepsy	Y	N	HIV	Y	N
Thyroid disease	Y	N	AIDS	Y	N

Do you have any of the following?

Itchiness	Y	N	Nose bleeds	Y	N
Dry skin	Y	N	Swelling in hands/feet	Y	N
Oily skin	Y	N	Wheezing	Y	N
Irritated lesions	Y	N	Abdominal pain	Y	N
Changing lesions	Y	N	Joint pain	Y	N
Fever	Y	N	Headache	Y	N
Fatigue	Y	N	Depression	Y	N
Excessive sweat	Y	N	Recent weight gain	Y	N
Dry eyes	Y	N	Recent weight loss	Y	N
Itchy eyes	Y	N	Swollen glands	Y	N

Please identify any of the following that a family member may have had:

Skin cancer	Y	N	Lupus	Y	N
Melanoma	Y	N	Other cancer	Y	N
Atypical moles	Y	N	Diabetes	Y	N
Acne	Y	N	Sarcoid	Y	N
Eczema	Y	N	HIV	Y	N
Psoriasis	Y	N	AIDS	Y	N

Do you have a "Living Will" or Advance Directives? Y N
Do you spend long hours in the sun? Y N
Have you ever had a blistering sunburn? Y N
Do you smoke? Y N Packs per day: _____ **Females:** Pregnant or nursing: Y N
Do you drink alcohol? Y N Drinks per day: _____ Trying to get pregnant: Y N
Do you use illegal drugs? Y N Which drugs:_____

Name of current medication: (Including Aspirin, Birth Control, Vitamins Etc.)	**What are you taking this for?**
_____	_____
_____	_____
_____	_____
_____	_____

Drug Allergies: _____

E-PRESCRIBE CONSENT FORM

E-Prescribe is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribe greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an E-Prescribe 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.

By signing this consent form you are agreeing that Advanced Medical & Cosmetic Center, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Advanced Medical & Cosmetic Center, LLC to enroll me in the E-Prescribe program.

Consent Accepted:

Patient Name (Print) _____

Signature: _____ Date_____

Relationship to Patient: _____

Advanced Medical & Cosmetic Center, LLC

Co-payments and Deductibles: Payments is required for all services at the time they are rendered. All applicable co-payments and deductible will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balance owing that are past due. I further acknowledge that I am responsible for the coinsurance and/or deductible under my health plan's agreement and should Advanced Medical & Cosmetic Center be required to send me to a collection agency, I shall be responsible for 30% fee added to the outstanding balance. Your signature below signifies understanding of this policy.

Patient Signature: _____ Date: _____

Referrals: If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, Advanced Medical & Cosmetic Center **will reschedule** my appointment.

Insurance Cards: All patients new and returning are required to present their insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance, coordination of benefits or contact information.

Patient Signature: _____ Date: _____

Cancellation Policy: Should you be unable to keep your appointment, please contact our office to cancel your appointment at your earliest convenience. Failure to contact our office within 24 hours of the appointment will result in a $35.00 no-show fee. This fee is not reimbursable by your insurance company.
** Suboxone Program patients will be charged a $50.00 no-show fee for failure to notify our office within 24 hours of their visit.

Patient Signature: _____ Date: _____

HIPPA Policy: Patient 18 years of age or older are protected under the Federal Health Insurance Portability and Accountability Act. This federal law prohibits any staff member of Advanced Medical & Cosmetic Center from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition, obtain results or appointments for you, please list their name(s) below. Only individuals names listed will be provided with information. Should you wish to update the names provided, please ask patient service representative at the front desk for a HIPPA form.

- May only speak to me _____ May email me at:_____
- May leave detailed message on the following phone number: _____
- You may speak to: _____(Name/Relationship) regarding my medical concerns.

Acknowledgement: I acknowledge having received a copy of Advanced Medical & Cosmetic Center's Notice of Privacy Practice related to the Health Insurance Portability and Act of 1996.

Patient Signature: _____ Date: _____

Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian: I certify that the information that I have provided is correct. I hereby assign to Advanced Medical & Cosmetic Center, any insurance or third party payment for health care services provided to me. I also understand that I am responsible for any co-insurance and/or deductibles at the time of service, as well as ensuring that I have a valid prior authorization and/or referral from my primary care physician.

Print Name:_____Date:_____

Advanced Medical & Cosmetic Center, LLC

POLICIES & PROCEDURES

Welcome to Advanced Medical & Cosmetic Center, LLC. In order to serve you better and avoid any misunderstanding**, please read and initial** each of the following:

1. It is **your responsibility** to understand your insurance. If you have a co-pay, deductable or co-insurance you will be asked to pay your balance prior to your office visit. Please be prepared to pay any balance you may have or you **will not be seen.** ____
2. We will not prescribe any controlled substance (ie. Xananx, Codeine, Percocet, Ambien, Lunesta, etc) without an office visit. ____
3. We will not refill any prescription if you have not been seen in the past 3-4 months. An office visit is required. Please be sure to **ask for refills** during your visit. ____
4. We are unable to provide phone consultations; therefore if you have a problem or your signs and symptoms are not improving we request that you schedule an office visit for a follow up evaluation. ____
5. We will not discuss lab results over the phone. You are required to make follow a follow up appointment to review your labs. It is your responsibility to call the office within 3-5 business days and our staff will let you know if your results are normal or abnormal. If all labs are normal, you have the right to cancel your appointment, otherwise, please keep your appointment to discuss results with your provider. ____
6. If you need a prescription refill please call your pharmacy and let them know which prescription needs to be refilled. Our office is electronic and the pharmacy will send us a refill request electronically. This allows for fewer mistakes with communication over the phone. ____
7. We are aware that some insurance's do not require a copay for an annual physical. However, please be aware that if any problems are addressed during your physical an additional copay may apply. ____
8. Please be advised that if you request a copy of your lab results that there is a **$3.00** charge. ____
9. We will not refill any prescriptions over the weekend. It is your responsibility to make sure your prescriptions are taken care of during our business hours. ____
10. Cancellations of appointments without a 24 hour notice deprives others the opportunity to be seen. Please be considerate, otherwise you will be charged a **$35 fee**. ____

I accept the above policy and procedures for Advanced Medical & Cosmetic Center, LLC

Patient signature:_____ **Date:**_____

Authorization to Release Records and Information

I, _____, born on _____
(Name of Patient) **(Date of Birth)**

Do herby consent and authorize _____
(Doctor of whom we are requesting records)

Located at _____
(Address)

to release my complete medical records to:

Advanced Medical and Cosmetic Center, LLC
208 Harristown Road
Glen Rock, NJ 07452
Phone: 201-882-1050 Fax: 201-882-1040

I understand that I have the right to revoke this Authorization at any time. I understand that in order to revoke this Authorization, I must do so in writing.

_____AFFIRMATION OF RELEASE_____

I give _____permission to release
(Doctor of whom we are requesting records)

All information from my complete medical records to:
Advanced Medical and Cosmetic Center, LLC

I terminate any agreements I have made with my providers to restrict my medical records and any associated HIPPA protected health information and I instruct my providers to release and disclose my entire medical record without restriction.

_____ _____
(Signature of Patient/Representative and Relationship) **(Date signed)**

Medications To Avoid Five Days Prior To Some Procedures

NSAIDS (Advil, Motrin, Ibuprofen)	Aleve
Aspirin	Midol
Vitamin E	Alka Seltzer
Green Tea	Ginger
Garlic	Red Wine
Ginko	Celery Root
Ginseng	Fish Oil
St. John's Wort	Kava Kava

To Help with Healing

Bromelain is a substance naturally present in the mature pineapple steams (Ananas comosus), and it contains proteolytic enzymes. Over the years, it has been used in medical settings for its antithrombotic, fibrinolytic and anti-inflammatory effects. Its use results in less edema, pain and inflammation. Although there is no standard recommended dose for bromelain consumption, this substance has been used in different doses ranging from 200mg to 2000mg.

Arnica also decreases bruising for the same reason and can be found in the tablets or cream form at most food stores.

******WHEN SCHEDULING APPOINTMENT PLEASE MAKE SURE TO TELL RECEPTIONIST YOU WOULD LIKE APPOINTMENT FOR "FILLER". This ensures plenty of time for perfection☺**

Advanced Medical & Cosmetic Center, LLC

MVA INFORMATION FORM

Please complete the form in its entirety. Failure to do so will result in a bill becoming the patient's responsibility until all of the information is received. Our staff will gladly assist you in any areas you do not understand. Thank you for your cooperation.

Patient Name _____ Date of Birth_____

Cell Phone _____ Home Phone _____

Date/Time of Accident _____ State the accident took place _____

Auto Insurance Company Name _____ Auto Ins. Company Phone _____

Auto Insurance Company Billing Address _____

Name of Auto Insurance Policy Holder _____

Accident Claim Number _____

Adjusters Name _____ Phone Number _____

Were you a pedestrian, passenger or the driver of the vehicle _____

Were you utilizing public transportation during the accident: Yes No
Is there an existing open claim: Yes No
Have you submitted the police report to your insurance company: Yes No
Have you completed your PIP application: Yes No

I, _____ agree to pay for services provided at Advanced Medical & Cosmetic Center if payment is denied for any reason. I authorize Advanced Medical & Cosmetic Center to submit claims on my behalf to the Auto Insurance listed above. If your account is forwarded to a collection agency 30% will be added to your outstanding balance.

Patient/ Guardian Signature _____ Date _____

208 Harristown Rd., Suite LL-2, Glen Rock, NJ 07452
Phone: (201) 882-1050 Fax: (201) 882-1040

Advanced Medical & Cosmetic Center, LLC

WORKERS COMPENSATION INFORMATION FORM

Please complete the form in its entirety. Failure to do so will result in a bill becoming the patient's responsibility until all of the information is received. Our staff will gladly assist you in any areas you do not understand. Thank you for your cooperation.

Patient Name _____ Date of Birth_____

Cell Phone _____ Home Phone _____

Occupation _____

Date/Time of Accident _____ State the accident took place _____

Employer Name _____

Contact Name _____ Phone Number _____

Employer Address _____

City _____ State _____ Zip code _____

Workman's Compensation Carrier _____

Phone Number _____

Date Authorization Obtained _____ Authorization Number _____
Is there an existing open claim: Yes No

I, _____ agree to pay for services provided at Advanced Medical & Cosmetic Center if payment is denied for any reason.

Patient/ Guardian Signature _____ Date _____

208 Harristown Rd., Suite LL-2, Glen Rock, NJ 07452
Phone: (201) 882-1050 Fax: (201) 882-1040