THE CUTANEOUS LASER CENTER, LLC.

Name_____ Today's date_____
Last First Middle

Address_____
Number, Street, Apartment Number City State Zip

Home Phone_____ Cell Phone_____

Date of Birth _____Sex_____ SS#_____

Employer's Name _____Employer's Telephone Number_____

Name of Pharmacy you use:_____ Pharmacy Phone:_____

Primary Care Physician_____Phone:_____

Who referred you to our office:_____

Do we have permission to: Leave a message on your home answering machine: **Y N**
Leave a message for you at work **Y N** Discuss your medical condition with another person **Y N**

If yes, whom_____ Relationship to Patient_____

GUARANTOR (RESPONSIBLE PERSON) INFORMATION

Guarantor Name_____Relationship to Patient_____

Address_____
Number, Street, Apartment Number City State Zip

Date of Birth:_____ Home Phone_____

Employer's Name _____Employer's Telephone Number_____

EMERGENCY CONTACT

Name: _____Phone_____ Relationship to Patient_____

INSURANCE INFORMATION

Insurance Company Name:_____ Policy #_____

Address:_____

Subscriber's Name: _____Relationship to Patient_____

PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST

Your signature authorizes the doctor to release medical information necessary to process your insurance claims.Payment is expected at the time of services for your portion of the charges. We accept Visa, MasterCard or American Express for your convenience.

_____ _____
PATIENT, PARENT OR GUARDIAN SIGNATURE Date

THE CUTANEOUS LASER CENTER, LLC.

Are you allergic to any medications Yes No If yes, please list;

1._____ 2._____

3._____ 4._____

List all medications you are currently taking:

1._____ 2._____

3._____ 4._____

HISTORY OF DISEASES

Do you now have or have you had diseases or conditions of:

Lungs:

Bronchitis Yes No
Emphysema Yes No
Asthma Yes No
Chronic cough Yes No
Morning cough Yes No

Vascular:

High Blood Pressure Yes No
Chest Pain Yes No
Heart Attack Yes No
Heart Murmur Yes No
Irregular Heartbeat Yes No
Pacemaker Yes No
Phlebitis Yes No

Other Systemic:

Diabetes Yes No
Thyroid Yes No
Kidney Yes No
Bladder Yes No
Stomach Yes No
Bowel Yes No
Hepatitis/Yellow skin Yes No
Glaucoma Yes No
Arthritis/Joint deformity Yes No
Convulsions, Epilepsy or Seizures Yes No
Fainting Yes No

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 (Novocaine)? Yes No Any bad reaction? Yes No

Skin:

When you are exposed to the sun, do you _____Tan only _____Tan and burn _____Bum
Have you ever had skin cancer? Yes No
Has anyone in your family had skin cancer? Yes No
Do you have a history of any specific skin diseases Yes No

If yes, please list:_____

_____

List any other diseases or conditions we should know about:_____

_____

_____

THE CUTANEOUS LASER CENTER, LLC.
501 Marshall Street, Suite 601
Jackson, MS 39202
Telephone 601-360-0050

We at The Cutaneous Laser Center are committed to providing you with the best possible medical care at the lowest possible aost. We regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have outlined the following provisions of our financial policy:

- All co-payments and deductibles are due and payable at the time of service.
- We accept cash, checks, money orders, VISA, and MasterCard
- Previous patient due balances must be paid within 30 days unless a signed payment plan has been approved by our Office Manger
- A $35.00 fee will be assessed for any check returned by your bank due to insufficient funds.

Billing your insurance: We are anxious to help you receive your maximum allowable benefits and will be happy to file the claim for you. We participate with most of the major payers, including Medicaid, Blue Cross and Aetna. However, if your insurance company has not paid your account in full within 90 days, the balance will automatically become your responsibility. In the event your balance for services rendered is not covered by insurance, you will be required to pay the following at the time of the service:

- The first $100.00 not covered by insurance
- For charges greater than $100.00, you will be required to pay up to $150.00 and pay the remaining balance within 30 days unless a payment plan has been approved by our Office Manager.

Summary: Our staff is trained to help you with any insurance questions you may have. We believe that a good physician / patient relationship is based upon understanding and good communications. Thank you for understanding and complying with our Financial Policy. If you have any questions about charges, payments, and payment arrangements, please feel free to contact our Office Manager at 601-360-0050. We are here to help you.

I have read and understand the practice's policy and I agree to be bound by its terms. I also understand and agree that such terms may b e amended by the practice from time to time.

_____ _____
Patient, Parent, or Guardian Date

_____
Printed Name of Patient

THE CUTANEOUS LASER CENTER, LLC.

CONSENT TO OPERATION, ANESTHETICS, OR OTHER MEDICAL SERVICES

I hereby authorize Dr. Sabra Sullivan and / or such assistants as may be selected by her, to perform the following procedure s : _____

_____

on _____
NAME OF PATIENT

The nature and purpose of the operation, possible alternative methods of treatment, the risks involved and the possibility of complications have been fully explained to me. No guarantee or assurance has been given by anyone as to the results that may be obtained.

I recognize that, during the course of the operation, unforeseen conditions may necessitate additional or different procedures than those set forth above. I, therefore, further authorize and request that the above named surgeon, his assistants, or his designees, perform such procedures as are, in his professional judgment, necessary and desirable, including but not limited to, procedures involving pathology and radiology.

I consent to the administration of such anesthetics as may be considered necessary or advisable by the physician responsible for this service with the exception of _____
SPECIFY OR STATE NONE

I consent to the photographing of the operations or procedures to be performed, including appropriate portions of my body, for medical, scientific, or educational purposes, provided my identify is not revealed by the pictures or by descriptive texts accompanying them.

The operation / procedure has been fully explained to me by Dr. Sullivan and I understand the consequences that my result from it. As an adult, or parent or Guardian of Patient, without reservation or duress, I hereby release and hold harmless of any liability The Cutaneous Laser Center, LLC. and / or any physicians, technicians, nurses or other authorized personnel participating in this medical procedure.

_____ _____
Patient, Parent, or Guardian Date

_____
Witness Date

THE CUTANEOUS LASER CENTER, LLC.
501 MARSHALL STREET, SUITE 606
TELEPHONE - 601-350-0060

PERMISSION ORM

I give the following people listed below permission to seek medical attention for my child or to obtain information regarding his/her/ my medical records.

_____

_____

_____

_____

_____

_____
Signature of Parent/Legal Guardian/Child

_____
Date

PRIVACY NOTICE

The Health Insurance Portability Accountability Act of1996 HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. This explanation is described fully in our Notice of Privacy Practices. This Notice is posted in the reception room of the Clinic or you may request a copy from the office by phone or in person.

By signing below, you acknowledge that a Notice of Privacy Practices has been made available to you.

_____

Patient's Signature

_____

Date

Do we have permission to leave a message on your answering machine Yes No