PATIENT INFORMATION

Patient Name:	Date of Birth:
Sex: ❒ M ❒ F	Marital Status: ❒ S ❒ M ❒ W
Social Security Number:	Preferred Language:

Address:			
City:	State:		Zip Code:
Home Phone:	Work Phone:	Cell Phone:	Email:
Referred By:			

Race

❒ American Indian or Alaska Native	❒ Korean	❒ Other Pacific Islander (ex: Fijian, Tongan)
❒ Asian	❒ Other Asian (ex: Hmong, Laotian, Thai)	❒ Other Race
❒ Black or African American	❒ Other Pacific Islander (ex: Fijian, Tongan)	❒ Samoan
❒ Chinese	❒ Other Race	❒ Vietnamese
❒ Filipino	❒ Other Asian (ex: Hmong, Laotian, Thai)	❒ White
❒ Guamanian or Chamorro	❒ Other Pacific Islander (ex: Fijian, Tongan)	❒ Decline to Disclose

Ethnicity

❒ Not Hispanic or Latino	❒ Hispanic or Latino (please choose below)	❒ Chicano
❒ Unknown	❒ Mexican	❒ Puerto Rican
❒ Decline to Disclose	❒ Mexican American	

Preferred Pharmacy:		Phone Number:
Cross Streets	City	Zip Code:

Do you use Tobacco: ❒ Never Smoked ❒ Former Smoker ❒ Current Smoker - # of Cigarettes Smoked Per Day _____

Allergies (Please include all)	Symptoms of Allergies

Current Medications	Dose and Frequency

Financial Policy

In order to establish optimal customer service and avoid misunderstandings or confusion regarding our payment policies, please be sure to inquire about our financial policy at our reception area. Payment is required for all services as rendered. Due to individual skin characteristics, we are unable to guarantee results from any product, procedure, or service. Sales and final and no refunds will be issued. If you wish to participate in any of the financial or promotional plans offered by this office, please discuss with a corresponding consultant prior to treatment. Patients must pay applicable co-payments, cosmetic balances and deductibles on the date of visit. We accept payment in the form of cash, check, credit card or debit card.

Your signature below signifies your understanding and willingness to comply with the policy.

_____ _____

Signature of Patient / Responsible Party | Date

_____ _____

Print Name | Relationship to Patient

MEDICAL QUESTIONNAIRE

Patient Name:	Date:
(CC) Reason For Visit:	
Skin Area Involved:	How Long? (Time):

Associated Symptoms (Pain, Itch, Etc.)	
1.	Severity: 1 2 3 4 5 6 7 8 9 10
2.	Severity: 1 2 3 4 5 6 7 8 9 10
3.	Severity: 1 2 3 4 5 6 7 8 9 10
4.	Severity: 1 2 3 4 5 6 7 8 9 10
5.	Severity: 1 2 3 4 5 6 7 8 9 10

Previous Treatments	
1.	Effectiveness: ❒ None ❒ Poor ❒ Fair ❒ Good
2.	Effectiveness: ❒ None ❒ Poor ❒ Fair ❒ Good
3.	Effectiveness: ❒ None ❒ Poor ❒ Fair ❒ Good

Other:

My General Health Is: ❒ Poor ❒ Fair ❒ Good ❒ Very Good ❒ Excellent

Acne Problems	❒ Yes ❒ No	Diabetes	❒ Yes ❒ No
Breast Pain/Back Pain/Breast Rash/Breast Surgery	❒ Yes ❒ No	Eczema	❒ Yes ❒ No
Breathing Difficulties (deviated septum, nasal sprays)	❒ Yes ❒ No	Hepatitis C	❒ Yes ❒ No
Cardiovascular Problems or Chest Symptoms	❒ Yes ❒ No	HIV / AIDS	❒ Yes ❒ No
Currently Pregnant (Males Leave Blank)	❒ Yes ❒ No	Psoriasis	❒ Yes ❒ No
Discoloration / Stretch Marks	❒ Yes ❒ No	Skin Cancer	❒ Yes ❒ No
Dry Skin / Itchy Skin	❒ Yes ❒ No	Stomach Ulcers	❒ Yes ❒ No
Pacemaker / Rhythm Abnormalities	❒ Yes ❒ No	Tuberculosis	❒ Yes ❒ No
Recent Illness / Weight Loss / Weight Gain	❒ Yes ❒ No	Hernias (Abnormal Scars, Belly Button)	❒ Yes ❒ No
Vision Problems when Driving or Tired/Droopy Eyelids	❒ Yes ❒ No	Other:	❒ Yes ❒ No

Past Surgeries	Year	Past Surgeries	Year
1.		4.	
2.		5.	
3.		6.	

If YES on any of the above, Describe conditions or Other Medical Problems (if applicable):

_____

_____

Family History of Skin Cancer and/or Skin Disease (Please Describe):

_____

_____

Social History

Do You Use: Alcohol ❒ Yes ❒ No ❒ Social ❒ Mild Moderate ❒ Heavy
Tobacco ❒ Yes ❒ No # of Packs Smoked Per Week: _____
Illicit Drugs ❒ Yes ❒ No Overexposed to the sun? ❒ Yes ❒ No

_____ _____
Signature of Patient / Responsible Party Date

_____ _____
Print Name Relationship to Patient

PAYMENT POLICY

Thank you for choosing our medical practice. We are committed to providing you the best possible medical care. The following information is provided to avoid any confusion regarding payment for professional medical services. Our Insurance Billing Department will work with you to see that your claim is filed accurately and promptly.

Please sign below that you have read and agree to this Policy.

- **All deductibles and co-payments will be collected in *full* at the time of service.**
- If we are in-network with your insurance plan, we will ***not*** discount our services by any further amount after your insurance company has processed your claim and informed us of your responsibility.
- If we are not a contracted provider for your insurance company, we will bill them, as a courtesy, on your behalf.
- **It is our preference to establish a credit card payment plan that we will use for settlement of all your account balances.**

I authorize the Advanced Dermatology and Skin Care Institute to charge outstanding balances on my account to the following credit card:

Visa Mastercard American Express Other:_____

Account Number:_____Exp. Date:_____CVV/CVC Code:____

Name on Card (Print):_____

Signature:_____ Date:_____

- **PLEASE NOTE: Unpaid account balances will be assessed a $10.00 re-billing fee for each statement generated after 90 days have passed. Late fees will begin accruing after 90 days.**
- If your account is overdue for more than 120 days after your insurance has paid, it will be referred to a collection agency. This is done reluctantly, as a last resort, after we have exhausted all efforts for voluntary payment.
- **New Patients, and those who have no insurance, are required to pay at the time of service with either a credit card or cash. We do not accept personal checks.**
- **Chemical Peels are no longer covered by most insurance companies.**

Acknowledgement and Authorization
I have read, understand and agree to abide by the above payment policy. I understand that charges not covered by my insurance company, as well as co-payment and deductibles, are my responsibility.
I authorize my insurance benefits to be paid directly to: _____

One-Time Authorization For Medicare recipients:
I request that my payment of authorized Medicare benefits be made to me on my behalf to Michael T. Lin MD., Inc for any services furnished me. I authorize holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. Additionally, I request that payment of authorized Medi-gap benefits be made to either me or on my behalf to Michael T. Lin MD., Inc. for any services furnished by this provider. I authorize any benefits or the benefits payable for related services.

_____ _____
Signature of Patient / Responsible Party Date

_____ _____
Print Name Relationship to Patient

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our office has copies of the HIPAA Notice of Privacy Practices available.
Please feel free to get a copy or ask a staff member to hand one to you.
I have read/understand the full Notice of Privacy Practices.

Patient Name:_____

I have read/understand the full Notice of Privacy Practices.

_____ _____
Signature of Patient / Responsible Party Date

_____ _____
Print Name Relationship to Patient

ACKNOWLEDGMENT: OFFICE POLICY FOR NO SHOW PATIENTS

No Show Policy:
Please notify our office **48 hours in advance** if you are unable to keep your scheduled appointment. If you do not notify us and **miss your appointment by not showing up at all,** we will require that you pay a **$75.00 Missed Appointment Fee** before we will book you another office visit.

Patient Name:_____

I have read/understand the full Office Policy for No Show Patients.

_____ _____
Signature of Patient / Responsible Party Date

_____ _____
Print Name Relationship to Patient