BEHR
LASER & SKIN CARE CENTER

Patient Information (Please Print Legibly)

Email: _____

Name: (First, Middle, Last) _____ **Date of Birth:** _____

Address: _____ **(City, State, Zip)** _____

Social Security or DL #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ **Cell Phone:** _____ Work Phone: _____ **Preferred Name:** _____

Preferred Pharmacy: _____ Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

In case of an emergency, Contact? Name: _____ Phone: _____ Relationship: _____

How were you referred to our office? (Patient, online, yellow pages etc.) Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I understand Kathleen L. Behr M.D. is only contracted with Medicare Part B and does not submit claims to secondary insurances or bill out of network. If Medicare is unable to forward claims to my secondary and/or supplemental insurance, the balance is my responsibility to pay.

Cosmetic service appointments require a deposit at the time of scheduling. I understand a 48-hour cancellation notice is required, otherwise my deposit will be forfeited.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____

NOTICE OF PRIVACY PRACTICES CONSENT FORM

By my signature below, I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Kathleen L. Behr M.D. and Behr Laser & Skin Center.

_____ _____

Print Name of Patient or Personal Representative | Signature of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority | Date

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Patient Confidentiality Office Policy

I. Objective:

To provide a control for the maintenance and release of patient health Information.

II.
Policy:

The health record is the property of Kathleen L Behr M D and shall be maintained to serve the patient, the health care carrier and Kathleen L Behr M D in accordance with legal, accrediting and regulatory agency requirements. The information contained in the health record belongs to the patient, and the patient is entitled to the protected right of his/her information. All patient care information will be regarded as confidential and available only to authorized users. **III. Data Collection:**

All individuals engaged in the collection, handling or disclosure of the patient health information shall be specifically informed of their responsibility to protect patient data and of the penalty for violation of this trust. Proven violation of confidentiality of patient information shall be cause of immediate termination of access to further data, with possible termination of any employee-employer relationship without option for rehire. **IV. Storage:**

a) All primary health records kept on paper shall be housed in physically secure areas. All computerized patient health records are to be accorded to the same high level of confidentiality given to manually kept records and all policies herein stated apply to computerized patient health records as well as manually kept records.
b) Primary health records (from this office) and secondary health records (records obtained from another physician) shall be retained according to legal, accrediting and regulatory agency requirements.
c) Original health records may not be removed from the premises, except under a court order, request of the physician, or to be stored in an outside storage unit.
d) Access to areas housing health information records shall be controlled by the Office Manager with the exception of the physician.
e) Health care records shall not be left unattended in areas accessible to unauthorized individuals.

V.

Access:

a) All requests for health records shall be directed to the Office Manager. Authorization for access to patient information is based on the need to know in order provide health care and related services required by the patient. All employees shall maintain patient information in the strictest confidence, sharing it only with others who have a need to know in order provide services to the patient. They shall guard against inadvertent release of information by avoiding the discussion of patient information in public areas.

b) Release of information from the health record shall be carried out in accordance with all applicable legal, accrediting and regulatory agency requirements, and in accordance with written institutional policy.

c) Direct access to patient health records for routine administrative functions, including billing, shall not be permitted, except where the employees are instructed in policies on confidentiality and subject to penalties arising from violation of these specified in

III.a.

d) All information contained in the health record is confidential and the release of information will be closely controlled. Medical records shall be released when:

1. It is required by law
2. For release to another health care provider currently involved in the care of the patient
3. For medical care evaluation
4. For research and education
5. For accreditation surveys

e) Health records shall be made available for research to individuals who have obtained approval for their research from the appropriate staff. Data complied as part of research studies may not include patient identity or other information which could identify the patient unless prior authorization has been obtained.

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Patient Medical History / Update

Patient Name:_____ **Date of birth:**_____

Do you wear sunscreen daily? ☐Y ☐N If so, what SPF?_____

Do you have a medical grade home skin care regime? ☐Y ☐N

When exposed to sunlight, do you:

☐ Always burn
☐ Usually burn, rarely tan
☐ Often burn, tan slowly
☐ Sometimes burn, tan well
☐ Rarely burn, always tan
☐ Never burn, tan deeply

Medical History: (Check all that apply)

☐ Acne
☐ Actinic Keratosis
☐ Anxiety
☐ Arthritis
☐ Autoimmune disorder: (RA, lupus, ms etc.)
Specify disorder: _____
☐ Basal Cell Carcinoma
☐ Blood clotting abnormalities
☐ Bone marrow or organ transplant
☐ Cancer:_____
☐ Cold sores
☐ Diabetes
☐ Depression
☐ Eczema
☐ Hearing loss
☐ Heart condition
☐ Hepatitis:_____
☐ Herpes
☐ High blood pressure
☐ HIV/AIDS
☐ Hormone imbalance
☐ Melanoma
☐ Psoriasis
☐ Squamous Cell Carcinoma
☐ Seizure disorder
☐ Stroke
☐ Thyroid disease

Do you have any other health problems or medical conditions not listed?_____

_____

Are you currently under the care of a physician: ☐Y ☐N If yes, for what?_____

Do you have an active infection? ☐Y ☐N

Have you had a recent sinus or upper respiratory infection? ☐Y ☐N

Have you had dental work and/or cleaning within the last 2 weeks? ☐Y ☐N

Are you scheduled for dental work and/or cleaning within 2 weeks following your cosmetic injections? ☐Y ☐N

Past Surgeries: (Check all that apply. List date and type of surgery)

☐ Cancer:_____ ☐ Heart:_____

☐ Joint:_____ ☐ Transplant:_____

☐ Splenectomy:_____ ☐ Hysterectomy:_____ ☐ Other:_____

Do you have a Pacemaker or Defibrillator? ☐Y ☐N

Do you have any metal in your body? ☐Y ☐N

Allergies: (Check all that apply)

☐ No known drug allergies
☐ Latex
☐ Adhesive
☐ Oral allergies:_____
☐ Topical allergies:_____
☐ Other:_____

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Patient Medical History / Update

Medications: (Please list all medication you are currently taking including over the counter vitamins)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Social History:

Smoking Status: ☐ Current ☐ Former ☐ Never

Alcohol Use: ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 + per day

Family History: (Check all that apply, write the family member relation; i.e. parent, sibling, child, etc.)

☐ Adopted ☐ Non-Melanoma skin cancer:_____

☐ Eczema:_____ ☐ Melanoma:_____

☐ Psoriasis:_____ ☐ Other:_____

Review of symptoms: (General: Check all that apply)

☐ Fever ☐ Chills ☐ Weight change ☐ Headaches ☐ Cough ☐ None

Women: Are you pregnant? ☐Y ☐N Breastfeeding? ☐Y ☐N

Are you taking any blood thinners (NSAIDS, aspirin, fish/flax seed oil, vitamin e) now or in the past week? ☐Y ☐N

Past Cosmetic Treatments: (Check all that apply)

☐ Botox ☐ Fillers ☐ Lasers:_____

☐ Body contouring ☐ Micro-needling ☐ Blepharoplasty

☐ Threads ☐ Facelift ☐ Chemical peels

☐ Other:_____ ☐ None

What can we help you with today?_____

_____

_____ _____

Patient Signature (or responsible party) Date: