OSCI
Ohio Skin
Care Institute

Patient Name _____ **Date of Birth**_____

Reason for your visit _____**Location** _____

Duration _____ **Symptoms** _____

Contributing factors (stress, hormones, sun) _____

Prior treatment (biopsy, medications, etc.) _____

LIST ALL **ALLERGIES** TO MEDICATIONS OR SUBSTANCES _____

LIST ANY ARTIFICIAL JOINTS, **PACEMAKER**, HEART VALVES REPLACEMENT _____

TO BE COMPLETED BY ALL WOMEN: Please inform the provider should you become pregnant during your treatment.

Are you pregnant or nursing? ☐ Yes ☐ No Are you currently planning a pregnancy? ☐ Yes ☐ No

PERSONAL HEALTH PROBLEMS: CHECK ALL THAT APPLY (EVEN IF MEDICATED)

SKIN:
- ☐ no problems
- ☐ abnormal scarring
- ☐ poor healing
- ☐ other skin conditions_____

HEMATOLOGIC/LYMPH:
- ☐ none ☐ other_____
- ☐ transfusions
- ☐ bleeding problems
- ☐ enlarged lymph nodes

CONSTITUTIONAL:
- ☐ none
- ☐ weight loss
- ☐ fever
- ☐ other_____

EYES/EARS/NOSE/THROAT:
- ☐ normal ☐ other_____
- ☐ glaucoma
- ☐ headaches
- ☐ plastic surgery_____

CARDIOVASCULAR:
- ☐ normal ☐ angina
- ☐ hypertension
- ☐ **artificial/mech valve**
- ☐ **pacemaker/defibrillator**
- ☐ other_____

INTESTINAL/URINARY:
- ☐ normal
- ☐ colitis
- ☐ stomach ulcer
- ☐ colon/bladder/kidney CA
- ☐ other_____

RESPIRATORY:
- ☐ normal
- ☐ asthma
- ☐ emphysema
- ☐ other _____

MUSCULOSKELETAL:
- ☐ normal
- ☐ arthritis
- ☐ **artificial joint** date_____
- ☐ other_____

NEUROLOGICAL:
- ☐ normal
- ☐ stroke
- ☐ seizures
- ☐ other_____

PSYCHIATRIC:
- ☐ normal ☐ depression
- ☐ claustrophobic
- ☐ anxiety attacks
- ☐ other_____

ENDOCRINE:
- ☐ normal
- ☐ diabetes type I___ II ___
- ☐ thyroid hypo __ hyper__
- ☐ other_____

INFECTIONS:
- ☐ none ☐ cold sores
- ☐ hepatitis ☐ MRSA
- ☐ HIV/AIDs ☐ TB
- ☐ STD_____

PAST HISTORY:

Previous Skin Cancers ☐ None ☐ Yes_____
Major Illnesses/Hospitalizations ☐ None ☐ Yes _____
Surgeries ☐ No ☐ Yes _____
Organ Transplant Recipient ☐ No ☐ Yes _____

FAMILY HISTORY:

Skin Cancer ☐ None ☐ Basal cell ☐ Squamous cell ☐ Melanoma ☐ Other skin conditions_____
Relationship: _____

SOCIAL HISTORY:

Occupation _____ **Marital status** ☐ **S** ☐ **M** ☐ **D** ☐ **W**
Do you wear ☐ Dentures ☐ Glasses ☐ Contact Lenses ☐ Hearing aides ☐ None
Smoking ☐ Never ☐ Former/when did you quit_____ ☐ Yes/# per day_____
Alcohol ☐ No ☐ Yes/drinks per week_____ **Alcohol or drug addictions** ☐ No ☐ Yes_____
Tanning bed use ☐ No ☐ Yes/last used _____ **Blistering sunburns** ☐ No ☐ Yes

Patient or Parent/Guardian Signature_____ **Date** _____

Providers Signature_____ **Date** _____

Medication List

Please **list all** your medications - prescription, over the counter, & any applied to skin, etc.

Name: _____ Date: _____

Name	Dosage	How many do you take?	How often taken

Ohio Skin Care Institute Registration and Patient Information Form

Mr /Mrs /Ms /Dr _____ _____ _____ _____

FIRST LAST MI Suffix or N/A

_____ _____ _____ _____

ADDRESS CITY STATE ZIP

_____ _____ _____

Home Phone (if none put N/A) Cell (if none put N/A) WORK (if none put N/A)

_____ _____ _____

PCP NAME ADDRESS PHONE

_____ GENDER ❑ M ❑ F MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Partner

DATE OF BIRTH

STUDENT STATUS *(circle):* Full time Part time Not a student EMPLOYMENT ❑ Full time ❑ Part time ❑ Retired ❑ Not employed

Did a Physician refer you? ❑ No ❑ Yes, Name: _____

I permit Ohio Skin Care Institute to disclose my protected health information; for the purposes of appointments/test results/procedure reminders and follow-up; by leaving such information in the form of a message on the following:

❑ Home answering machine ❑ Cell voice mail ❑ Office voice mail

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name of Individual(s) **Phone Number** **Relationship**

_____ _____ _____

_____ _____ _____

Advance directives (*please provide copies*): ❑ N/A ❑ DNR ❑ Living will ❑ Power of Attorney

Email (*if none, put N/A)* _____

Can we email you upcoming events or promotions? ❑ Yes ❑ No

	Primary Insurance	Secondary Insurance
Insurance Carrier Name		
Subscriber Name and Date of Birth		

Race ❑ American Indian ❑ Asian ❑ Black/African American ❑ Hispanic ❑ Caucasian ❑ Middle Eastern ❑ Refuse to report

Ethnicity ❑ Hispanic or Latino ❑ Hispanic or Latino ❑ Refuse to report Language ❑ English ❑ Spanish ❑ Russian ❑ Other

_____ _____

PATIENT / Legal Guardian SIGNATURE DATE

OSCI
Ohio Skin Care Institute

Cosmetic Intake Form

Patient name: _____

DOB: _____ Age: _____ Gender: M/F

Referred by or heard about us: _____

Interested in: _____

Skin Type Assessment:

Fitzpatrick skin type I II III IV V VI Ethnicity: _____

Last exposed to UV (sun or tanning bed): _____

Self tanning lotion Yes/No Passive Tan Yes/No

Recent wax or epilation Yes/No Retinoid use Yes/No

Medical History:

Pacemaker/Defibrillator Yes/No Metal Implants Yes/No

Pregnancy or nursing Yes/No Impaired immune system Yes/No

History of bleeding disorders Yes/No Photosensitive medications Yes/No

Diseases stimulated by light Yes/No Active infections Yes/No

Severe Concurrent medical conditions Yes/No_____

Current or history of melanoma and non-melanoma skin cancers Yes/No

History of internal cancers Yes/No History of bleeding disorders Yes/No

Medications:

_____

_____

Drug Allergies: _____

_____

Please complete and return this form, along with all other forms, to the receptionist.

Your Name: _____ Today's Date: _____

Your E-mail Address: _____

How did you hear about us? (check all that apply)

( ) Referred by a physician, whose name is _____

( ) Staff member at _____ (Physician's office).

( ) A friend or family member, whose name is _____

( ) Print ad _____ ( ) Our web page

( ) Radio ( ) City Scene magazine ( ) Your insurance company

( ) Other _____

Are you interested in any cosmetic procedures? ( ) Yes, please continue below ( ) No

Please check all that may apply

❒ Acne or chickenpox scars	❒ Repair Torn Earlobe	❒ miraDry® Sweat
❒ Botox®/Dysport®/Xeomin®	❒ Upper/Lower Eye Lift Surgery	❒ Effective Skin Care Regimen
❒ Sclerotherapy/Leg Veins	❒ Facials	❒ Make-up Application/Lessons
❒ Skin Rejuvenation	❒ Non-Surgical Face/Neck Lift	❒ Laser Hair Removal
❒ Brown or Red Spots/Veins	❒ Microdermabrasion	❒ CoolSculpting®/Fat Reduction
❒ Liposuction/Smartlipo	❒ Cellulite/Velashape	❒ Loose abdominal skin
❒ Crows feet and smile lines	❒ Scar Revision	❒ Registered Dietician Services
❒ Eyelashes/ Latisse®	❒ Chemical Peel	❒ Enlarged Pores
❒ Blotchy Skin	❒ Facial redness	❒ Loss of facial volume/jowls
❒ Facial Contouring	❒ Thin Lips	❒ Off-face rejuvenation (chest, hands)
❒ Facial Veins/Broken Capillaries	❒ Brown Spots/Freckles	❒ Loose Neck Skin
❒ Mole Removal	❒ Skin Tags/Seborrheic Keratoses	❒ Eyelash Extensions and/or Tinting
❒ Leg Veins/Spider Veins	❒ Excessive Sweating	❒ Facial wrinkling
❒ Fillers: Voluma/Juvederm®/Restylane®/Radiesse®/Sculptra®/Other		
❒ Other _____		

GENERAL CONSENT TO TREAT

Patient's Name:_____ DOB:_____

1. Consent. I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care. This care may include surgical and laboratory procedures; local anesthesia; therapeutic procedures; medications. I know procedures that have more risk will be explained to me so I can give informed consent for them. I know I can ask my doctor any question(s) I have about my treatment.

2. Release of information. I authorize OSCI, LLC to release pertinent information and/or copies of medical records for treatment, payment, or health care operations purposes. I understand such information may include human immunodeficiency virus (HIV), AIDS related complex (ARC), acquired immunodeficiency syndrome (AIDS), hepatitis, substance abuse, if any. See Notice of Privacy Practices for further information.

3. Human Immunodeficiency Virus (HIV) and Hepatitis B/C Testing. I understand and agree that, in accordance with State law, an HIV, HBV or HCV tests may be performed upon me in the event a health care worker sustains a significant exposure to my blood or body fluids. The results of any test will be treated confidentially.

4. Testing and Disposal of Specimens and Tissue. I authorize OSCI to retain, preserve, or use for research, scientific or teaching purposes, or to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.

5. Valuables. I release OSCI from responsibility for all personal articles which I have with me during the time I am at OSCI. I understand that OSCI is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession while at OSCI.

6. Payment. I assign and authorize payment from my insurance company directly to OSCI, LLC for any and all services rendered. I agree to pay all charges not covered by my insurance company. I understand that it is my primary responsibility to pay the charges for services rendered irrespective of any disputes or disagreements between myself and insurance companies.

7. Direct Financial Interest. Title 42 CRF 420 requires that a physician notify the patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and if these are available elsewhere on a competitive basis. We support this law because it helps patients make reasonable financial decisions concerning their medical care. In compliance with the requirements of this law, we have a direct financial interest in the diagnostic or treatment agency or in the non-routine good or services named below. Further, as indicated below, good or services that we have prescribed are available elsewhere on a competitive basis. DIAGNOSTIC OR TREATMENT AGENCY OR NON ROUTINE GOODS AND SERVICES: Ambulatory Surgical Services and Pathology Services. Are these available elsewhere on a competitive basis? Yes – at various hospitals and surgical centers in Franklin County. Mount Carmel East Hospital is the closest location.

8. In accordance with Federal Law, Ohio Skin Cancer Institute is notifying you that it <u>will not</u> honor advanced directives.

9. Under federal law Health Insurance Portability and Accountability Act restricts OSCI from discussing any medical information, unless a release form is signed. Please see the Notice of Privacy Practices Form.

- ☐ I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.
- ☐ I received a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities
- ☐ I acknowledge the Direct Financial Interest Disclosure
- ☐ I consent to pictures or videos being recorded or televised during my treatment, including appropriate portions of my body, for medical research or educational purposes, as long as my identity is not compromised or released.
- ☐ I agree that you may call me on whatever phone numbers I give you, including land lines, cell phones, Skype numbers, or anything else.

_____ _____ _____

Signature of Patient or Authorized Agent | Relationship to Patient | Date

FINANCIAL POLICY

Effective Date: March 24, 2016

Name: _____ DOB: _____

Thank you for choosing OSCI for your care. We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy. Please sign it prior to any treatment.

- Outstanding fees and co-pays are due at the time of the visit.
- Payment for non-covered or cosmetic procedure must be prepaid in full prior to the time of the visit/procedure.
- We accept cash, check or credit cards.
- 10% service charge will be added to bills over 30 days old.
- We offer an extended payment plan for patients meeting low income or financial hardship criteria.

It is essential that you bring your current primary and secondary insurance card to each visit, so that we have the most accurate and up-to-date information to submit charges to the insurance carrier on your behalf.

MEDICARE: We participate with Medicare and we accept assignment. You are responsible for 20% of Medicare's approved amount unless you provide our office with secondary insurance coverage at the time of service. We will file a claim with your secondary carrier. However, in the event that the secondary does not pay within 60 days, the patient will be billed.

SELF PAY: Payment for all services is due and payable at the time of service. Payment plans are on a case to case basis decided by the provider. We accept CareCredit.

PARTICIPATING PLANS (HMO/PPO): We will be happy to bill insurance plans we participate in. Once we receive correct payment, we will make our contractual adjustment and send you a bill for any balance due. These are due upon the receipt of your bill. If Dr. Ravitskiy or other OSCI medical care provider is a participating provider contracted with your insurance plan; copays are to be paid on the date of service. **It is your responsibility to know your coverage eligibility, deductibles, copays, referral and precertification requirements and whether or not your provider is on your plan.** If the expertise of an outside lab is needed for a portion of your care (biopsy interpretations or second opinions), you may receive a separate bill from that lab for their services.

NON-PARTICIPATING PLANS: As a courtesy to you, we will bill your insurance carrier if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account within 30 days, the account will be assessed for payment. You should remit payment within 30 days and contact your insurance company to check on status of claim. Please notify us immediately upon contacting your insurance company or if there is anything we can do to help settle this claim. If you have a non-participating Blue Shield plan which will send payments to you instead of the doctor, we will ask for full payment from you on the day of your visit. Then we will bill Blue Shield on your behalf and Blue Shield will reimburse you directly. When you arrive for your visit, you may be asked to sign a non-contracted waiver form, and you will have an opportunity to speak with our billing staff about the charges.

See reverse side

USUAL AND CUSTOMARY RATES:
Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in our area. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

AUTHORIZATIONS/ACKNOWLEDGEMENTS (For Medicare patient's only)

MEDICARE: I hereby authorize any provider of services to me who file claims to the Medicare Program, its intermediaries or carrier and to Medigap and any plan to which Medicare crossover to release medical or other information about me that is required for the adjudication of a claim submitted for care provided to me. I also assign payment of any health benefits due to me to the party who files an assigned claim to the Medicare program for services provided to me. This authorization is for my lifetime unless revoked in writing by me or my legal guardian or assign.

_____ _____ ___/___/___
Signature of Patient or Legal Guardian Relationship to Patient Date

APPOINTMENT CANCELLATION POLICY: Should you be unable to keep your appointment, please contact the office to cancel your appointment. **Failure to contact the office with at least 24 hour advance notice will result in a $50 fee. Surgical and cosmetic appointments require a 48 hour cancelation notice to avoid $100 fee**. This fee is not reimbursable by your insurance company.

MEDICAID WAIVER (all forms of Medicaid): OSCI does not accept Medicaid or any forms of Medicaid. I understand OSCI will not bill Medicaid, therefore if I have one of these insurances as my primary insurance I will be responsible for my entire bill at the time of service. I understand that if one of if these insurances is my secondary, I will be responsible for the amount my primary insurance does not cover. At my request OSCI will provide an estimate prior to receiving my services.

WE ACCEPT MOST MAJOR CREDIT CARDS INCLUDING CARE CREDIT FOR YOUR CONVENIENCE.
There will be a $35 charge for all checks returned for insufficient funds.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand and agree to this Financial Policy.

_____ _____ _____ ____/____/____
Signature of Patient or Legal Guardian Printed name Relationship Date

See reverse side

OSCI
Ohio Skin
Care Institute

Consent to Obtain External Prescription History

I, _____ (patient name) whose signature appears below, authorize Ohio Skin Care Institute and Its Affiliated Providers to view my external prescription history via the RxHub service.

I understand that the prescription history from multiple other unaffiliated providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

_____

Signature of Patient or Legal Guardian

_____

Practice Representative

If any prescriptions are written during your visit for convenience purposes we will E-prescribe them directly to the pharmacy.

_____	_____	_____
PHARMACY NAME	ADDRESS/CITY/ZIP	PHONE NUMBER

Cosmetic Services

- The charges quoted are valid for 6 months from proposal date.
- A deposit will be collected at the time of scheduling; this along with your consultation fee will be applied towards your procedure. Consultation fee discounts are valid for 90 days from the date of your consultation.
- Payment of 50% of the estimated cost of the procedure must be received 14 days prior to your surgery date. If payment is not received, your surgery will be cancelled. Acceptable forms of payment are cash, personal check, all major credit cards or CareCredit. The remaining balance and any additional services or charges accrued will be due on the day of service.
- The Aesthetic Fee includes postoperative office visits for 6 months from your procedure date. Non-related visits will be charged at the standard office visit rate(s).
- Charges for pre and post procedural prescriptions are not included in the fees indicated in consultation.
- Charges related to any procedural complications resulting in additional care and/or hospitalization will be your responsibility. An additional fee for any revisions performed may be charged if performed within 12 months of procedure.

I have read this entire document and have been given the opportunity to review and discuss the fee(s). I understand my financial obligations set forth herein. I understand that the procedure(s) is/are cosmetic and not covered by my insurance plan. My signature below is a statement of my understanding of and agreement with the information set forth on this document.

Signature Of Patient or Patient Representative	Date	Time
Signature of Practice Representative	Date	Time
Signature of Physician/PA/aesthetic nurse	Date	Time