sōna DERMATOLOGY

PATIENT HEALTH HISTORY

Full Name (Last, First, MI, "Nickname") _____ Date of Birth ___/___/___ Birth Sex M / F Race(s) _____ Today's Date: ___/___/___

Email _____ Height: _____ Weight: _____

Phone Numbers *Provide your contact number(s) and check the box below for your preferred contact number.*

☐ Mobile _____ ☐ Home _____ ☐ Work _____

May we leave a detailed message? ☐ Yes ☐ No

Home Address _____ City _____ State _____ Zip Code _____

Emergency Contact (Last, First) _____ Phone _____

Pharmacy Name _____ Pharmacy Address _____ Phone _____

Primary Care Provider - PCP (First & Last Name) _____ Phone _____

☐ *Check if you do not have a PCP*

Referring Provider (First & Last Name) _____ Phone _____

☐ *Check if PCP is same as Referring Provider*

MEDICAL HISTORY

Select past and present medical conditions you have experienced:

☐ **None**
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Atrial Fibrillation *(Irregular Heartbeat)*
☐ *Bone Marrow Transplantation*
☐ Depression
☐ Diabetes
☐ Heart Disease/Cardiac Condition
☐ Hepatitis
☐ Herpes
☐ HIV / AIDS
☐ Hirsutism
☐ Hypertension *(High Blood Pressure)*
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Seizures
☐ PCOS
☐ Shingles
☐ Stroke

Cancers Other Than Skin: *Include type/location and treatment(s)* _____

Additional Medical Conditions: _____

PAST SURGERIES

☐ **None OR List all past surgeries:** _____

SKIN DISEASE HISTORY

☐ **None** If you have had any of the following skin conditions, provide details below *(including treatment dates and location(s))*:

SKIN CANCERS

☐ Basal Cell Carcinoma _____
☐ Melanoma _____
☐ Precancerous Moles _____
☐ Squamous Cell Carcinoma _____

☐ Additional skin conditions, infections or allergies:
_____
_____

SKIN CONDITIONS

☐ Acne _____
☐ Cold Sores/Fever Blisters _____
☐ Dry Skin _____
☐ Eczema _____
☐ Psoriasis _____
☐ Rosacea _____
☐ Vitiligo _____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____ **Tanning salon usage?** ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)? _____

MEDICATIONS

List all medication names and dosages including over the counter, herbal supplements, prescription creams & skin care products.

☐ **No current medications** *(Examples: Retin-A, Renova, Differin, Tazorac, glycolic/AHA products)*

_____
_____
_____

Revised 4/12/22

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PATIENT HEALTH HISTORY

Full Name (Last, First, MI, "Nickname") _____ Date of Birth ___/___/___ Today's Date: ___/___/___

ALLERGIES

List all allergies and reaction(s), including medication, food, and environmental.

☐ **No known allergies**

SOCIAL HISTORY

TOBACCO USAGE

☐ Never ☐ Former ☐ Current If a smoker, number of packs per day: _____ Total years smoking: _____ Tobacco Type: _____

ALCOHOL USAGE

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?

Number of Days_____ ☐ None ☐ Decline to Specify

OCCUPATION: _____

AGE 65+ ONLY (SKIP THIS SECTION IF YOUNGER THAN 65)

Have you ever received a **pneumonia vaccination**? ☐ Yes ☐ No

Year of most recent pneumonia vaccination: _____ Vaccination(s) received (check all that apply): ☐ PPSV23 ☐ PCV13 ☐ Unsure

Do you have an **advance care plan/living will**? ☐ Yes ☐ No ☐ Decline to specify *(If no or decline, skip remaining questions)*

Do you have a healthcare proxy? ☐ Yes ☐ No Designee's Name/Phone Number: _____

Which statement(s) reflect your wishes: ☐ Do not intubate ☐ Do not resuscitate ☐ Full cardiopulmonary resuscitation

REVIEW OF SYSTEMS

Have you experienced any of these symptoms in the past week:

☐ **None** ☐ Fever/chills ☐ Rash ☐ Joint pain

ALERTS

Select all that apply:

☐ **None**
☐ Allergy to lidocaine
☐ Bleeding Disorder
☐ Blood Thinners
☐ Breastfeeding
☐ Diastatis Recti
☐ Eating Disorder
☐ History of hernia or hernia repair
☐ History of tanning bed usage
☐ Hormone Replacement Therapy
☐ Hyperhidrosis
☐ Hyperpigmentation *(Skin Darkening)*
☐ Hypopigmentation *(Skin lightening)*
☐ Immunosuppression
☐ Irregular Periods
☐ Isotretinoin *(Accutane)*
☐ Kidney disease
☐ Latex allergy
☐ Liver disease
☐ Lupus
☐ Menopausal *(1st 12 months)*
☐ Metal or other implants
☐ Organ transplant
☐ Pacemaker/Electric Device
☐ Pregnancy or planning pregnancy
☐ Problems healing
☐ Problems scarring *(hypertrophic or keloid)*
☐ Radiation/Chemotherapy
☐ Rapid Heartbeat/Sensitivity to Epinephrine
☐ Tattoos
☐ Thyroid problems

ADDITIONAL QUESTIONS

How did you hear about us? _____ ☐ Referring Provider

Have you had any previous laser, skin, Botox or filler treatments? _____

Which of the following concerns do you have about your skin/body?

☐ Acne
☐ Age Spots
☐ Aged Skin
☐ Cellulite
☐ Dry Skin
☐ Enlarged pores
☐ Hair Removal
☐ Leg Veins
☐ Melasma
☐ Oily Skin
☐ Pigment Changes
☐ Redness
☐ Rosacea
☐ Scars
☐ Sensitive Skin
☐ Skin Laxity
☐ Skin Texture
☐ Spider Veins
☐ Stubborn or pinchable fat
☐ Sun Damage
☐ Sweat/Odor
☐ Uneven Skin Color
☐ Whiteheads
☐ Wrinkles
☐ Other:

Which of the following services would you like to learn more about?

☐ Acne treatment
☐ Age spot treatment
☐ Botox
☐ Fat reduction
☐ Filler Injections
☐ Laser Hair Removal
☐ Laser Skin Rejuvenation
☐ Laser Vein Treatment
☐ Melasma
☐ MiraDry sweat & odor reduction
☐ Pigment Treatment
☐ Redness/Vessels
☐ Rosacea Treatment
☐ Scar Treatment
☐ Skin Resurfacing
☐ Skin Tightening
☐ Sun Damage Repair
☐ Wrinkle Treatment
☐ Other:

Revised 4/12/22

INFORMED PATIENT CONSENT: COVID-19 PANDEMIC

I understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact and accordingly, federal and state health agencies recommend social distancing.

I understand that even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that if I have a COVID-19 infection and even if I do not have any symptoms, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in any of the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, intensive care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some, or many of which may not currently be known at this time, in addition to the risks described in this Informed Consent, as well as those risks for the treatment/procedure/surgery itself.

I recognize that the medical providers and staff at Sona Dermatology and MedSpa are closely monitoring this situation and have put in place reasonable preventive measures targeted to reduce the spread of COVID-19. Given the nature of the virus, however, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery.

Accordingly, I acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for the medical providers and staff at Sona Dermatology and MedSpa to proceed with the same.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including, but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery. I acknowledge that I have been offered a copy of this consent form.

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE PROCEDURE.

Patient Name (Print)

Patient Name (Signature)

Relationship to Patient

Date

Practice Representative Name

Signature of Practice Representative/Witness

November 2021

sōna
DERMATOLOGY

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical and cosmetic care. Your clear understanding of our practice financial policy is important to our professional relationship. The following information outlines your responsibility related to payment and appointment reservation for professional services. To keep healthcare costs to an absolute minimum, we have adopted the following policies.

Insurance: At each medical dermatology visit, we must verify your current insurance. If we are unable to verify insurance coverage, you will be expected to pay at the time of service. If insurance information is provided, after the timely filing window, claims will not be filed, and you will be responsible for any remaining balance. It is your responsibility to know your benefits. Please contact your insurance company directly with any questions you may have regarding your coverage. You can be charged with out-of-network costs, if the provider that is providing care, is not in network with your insurance carrier. This means we may charge the full amount for your treatment and your insurance provider may not pay for these charges, leaving the payment your responsibility.

Self-Pay: Self-pay refers to a patient that pays their bill directly rather than going through a private insurance company. If you're self-pay, you understand that the cost of your visit, and any treatment(s) that are performed, are due at time of service. If your provider sends lab work and/or specimen(s) to an outside laboratory, you understand that you will be required to pay for additional fees directly to them.

Co-payment: All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Co-payment and co-insurance are determined by your insurance, not Sona Dermatology. We accept cash, Visa, MasterCard, American Express, Discover, Care Credit, Greensky, and personal checks. Please understand that we will only accept personal checks for medical dermatology purposes only. We will not accept personal checks for cosmetic services.

Deductible: An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay. It is your responsibility to pay any out-of-pocket expenses that are not covered by your insurance plan, including deductibles that are not met.

Credit Card on File: A credit card may be kept on file for any prearranged payment plans.

Referrals: If your insurance company requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain one. If the referral is not sent to us prior to your scheduled appointment you may be asked to reschedule the visit until we have a valid referral on file. It is also your responsibility to ensure that your PCP is listed correctly with your insurance company to match the referral that is obtained.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or legal guardian to their first appointment to meet the clinician and complete all necessary paperwork. A signed authorization from the parent or guardian allowing our clinician to provide medical treatment is available for subsequent visits. All co-pays or monies due are expected to be paid at the time of each services.

Determining Guarantor: The guarantor is the responsible party held accountable for this patient's bill. The guarantor is always the patient if they are over the age of 18. The guarantor for a minor child is the parent that presents the child for care at the time of the initial visit.

Non-Payment: If your account is 120 days past due, we will refer your account to an external collection agency. The collection vendor may report your delinquency to credit bureau and may file litigation in efforts to collect the total balance due. Any litigation fees will be applied to the collection balance.

Returned Checks: Sona Dermatology will charge a $25 fee for any returned checks.

Missed Appointments: If you are unable to keep your appointment please notify our office at least 24 hours in advance. Failure to provide 24-hour notice will result in a no-show charge and will be collected to extent permitted by law or applicable payor contracts. The no-show and/or same day cancellation fee is $75 for both medical and cosmetic appointments. No-show and same day cancellation fees will not be billable to your insurance.

November 2021

Refunds: I understand that all sales are final once treatments have begun and if I should choose to discontinue treatments, I will be entitled to a credit against other services or products offered by Sona Dermatology. The credit will be based on the unused treatments remaining in my treatment plan and calculated using the remaining portion of my account balance less the full individual price of treatments received. All individual single treatment price have been explained to me. I will be entitled to a refund only if I request it within 14 days of the date of purchase and prior to beginning the first treatment of my treatment package(s) but understand that a $100 administrative fee will be assessed.

Cosmetic Expiration: I understand that I will forfeit any treatments remaining, in my treatment packages, after one year from the start of my treatments. In addition, I understand that I will forfeit any unused treatments after two years from purchase.

Sun Exposure: At Sona Dermatology, your safety is our primary goal. To operate our lasers with the utmost safety we ask that you review and understand our sun exposure guidelines. Please understand that for most laser treatments, you must refrain from active sun tanning, tanning bed exposure, tanning creams/lotions, etc. for 2 weeks prior to appointment. If you are unsure about what lasers may be affected by sun exposure, please contact our office prior to your scheduled appointment. If you have received sun exposure or used anything that would prevent you from being able to treat, and need to reschedule, you will need to provide Sona Dermatology with a 24-hour notice. If you feel unsure about sun exposure, topical product, or medicines you may be on please contact our office.

I have read and understand the financial policy and agree to its terms. I understand that this financial policy is active for one year. I understand that I will need an updated and signed financial policy on file every year. I understand that individual results of any treatment, procedure, or service will vary and no guarantee is stated or implied by any Sona Dermatology provider. The exact individual patient experience will be unique and vary according to each individual patient. In addition, having more than one or several treatments may or may not provide desired outcomes.

_____ _____

Signature (Patient/Legal Guardian) Relationship to Patient

_____ _____

Patient Printed Name Date