Dear Valued Patient:

Thank you for choosing Commerce Institute of Skin, the office of Dr. Annette C. LaCasse. We look forward in seeing you for your future appointment.

In order for us to serve you better, please take the time to fill out the enclosed new patient forms. You may fax them back to us prior to your appointment or bring them in with you on the day of your appointment.

If you would rather fill out the forms when you arrive, please allow at least **15 minutes** prior to your appointment time to expedite your service. **Please bring with you a copy of your insurance card and photo identification.**

We look forward to helping you with all of your skin-related concerns and thank you again for choosing Commerce Institute of Skin.

Warm Regards,
Dr. Annette C. LaCasse

Medical History

Annette C. LaCasse, D.O. P.C.

NAME____**DOB:**____________________ **DATE:**__________

Please place a check mark by any condition you have now or a history of:

Skin disease history

- □ Actinic Keratosis
- □ Basal Cell skin cancer
- □ Squamous cell skin cancer
- □ Melanoma: Year__________
- □ Flaking or itchy scalp
- □ Hay fever/allergies
- □ Hair problems
- □ Blistering sunburns
- □ Psoriasis
- □ Sensitive skin
- □ Dry skin
- □ Skin Allergies
- □ Other_______________

Medical history

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial fibrillation/irr. Heart beat
- □ Bleeding/clotting disorder
- □ Colon problems
- □ COPD/emphysema
- □ Coronary Artery disease
- □ Depression
- □ Diabetes (type) ________
- □ Epilepsy
- □ GERD
- □ Head injury
- □ Hearing Loss
- □ Heart Attack
- □ Hepatitis – Type___
- □ High Blood pressure
- □ HIV/AIDS
- □ Hypercholesterolemia (high cholesterol)
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Migraines
- □ Prostate problems
- □ Radiation Treatment
- □ Seizures
- □ Stomach ulcers
- □ Stroke
- □ Other__________________
- □ Cancer – Type___________

Social history

□ Tobacco use □ Marijuana use □ Alcohol use □ Drug Use

Past surgical history including cosmetic surgery

Please list all previous surgeries

Surgery	Date	Surgery	Date

Family History

Mother	□ Living	□ Deceased	Age____
Father	□ Living	□ Deceased	Age____

Skin Cancer

- □ Basal cell carcinoma
- □ Squamous cell carcinoma
- □ Melanoma
- □ Other ________________

Other diseases

- □ Lung disease
  Asthma, Emphysema, COPD
- □ Cardio-vascular disease
  Heart attack, stroke
  High cholesterol
  High blood pressure
- □ Arthritis
- □ Cancer _________________
- □ Colon disease
  Crohn's, Colitis
- □ Kidney disease
- □ Diabetes
- □ Seizures
- □ Anxiety
- □ Depression
- □ Thyroid problems

Medical History

Annette LaCasse, D.O., P.C.

Family History: (Past family and social history)

Mother: ___ Living ___ Deceased ___ Age
Father: ___ Living ___ Deceased ___ Age

Check the following medical conditions that have occurred in your **family**:

Disease	Mother	Father	Blood Relative
Malignant Melanoma	______	______	______________
Non-Melanoma Skin Cancer	______	______	______________
Allergies	______	______	______________
Arthritis	______	______	______________
Asthma	______	______	______________
Diabetes	______	______	______________
Eczema	______	______	______________
Hay fever	______	______	______________
Heart Disease	______	______	______________
High Blood Pressure	______	______	______________
Lung Disease	______	______	______________
Psoriasis	______	______	______________
Tuberculosis	______	______	______________
Other Cancers	______	______	______________

Is there any other family history you think we should know about?______________________________

____

____

MEDICATION LIST

Name:	Pharmacy:
Birthdate:	Pharmacy Phone Number:

Allergic To/Describe Reaction:	Allergic To/Describe Reaction:

List **ALL** prescription and over-the-counter (non-prescription) medications such as vitamins, Aspirin, Tylenol, and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort)
Include all meds taken as needed, (ex. Viagra, Nitroglycerin, Motrin).

Date	Medication Name	Dosage	Frequency	Route of Administration	Date Began/DC'd
					/
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PATIENT DEMOGRAPHICS

Annette LaCasse D.O., P.C.

Patient Name ____________________ **Birthdate** ___/___/_____ Age____ M___F___

Address ____________________ **Email** ____________________________________

City ____________________

Zip/ State ____________________ S.S. Number_____-____-________

Phone (_____)-_____-_______

Cell (_____)-_____-_______ Referred by ______________________________

What is your preferred method of contact? (choose one)___phone call ___text message ___email

Emergency Contact

Name____________________ Phone Number(_____)-_____-_______

Relationship_______________

INSURANCE INFORMATION

Insurance Company_________________ Policy Number______________________

Policy Holder Name _________________ **Date of Birth:** ___/___/_____

Policy holder S. S. Number:______-____-________ Employer___________________________

Insurance Company_________________ Policy Number______________________

Policy Holder Name _________________ **Date of Birth:** ___/___/_____

Policy holder S. S. Number:______-____-________ Employer___________________________

Insurance Company_________________ Policy Number______________________

Policy Holder Name _________________ **Date of Birth:** ___/___/_____

Policy holder S. S. Number:______-____-________ Employer___________________________

Social History

Do you live alone? Yes ___ No ___ Married: N___ Y___ Spouse's Name:_____________________

Number of Children_____

Name of Children__________________________ Age_____

__________________________Age_____

__________________________Age_____

__________________________Age_____

Hobbies/Leisure activities: ___________________ Occupation________________________________

Patient Signature __________________________ Date___/___/_____

Insurance Provider List

Here are the more common insurances we accept:

Aetna (PPO and Medicare Advantage)
Blue Care Network
BCBS (PPO and Medicare Advantage)
Cofinity
Medicare
Humana Medicare Advantage PPO
Priority Health (all plans except Medicaid)
United Health Care PPO
Cigna HAP
HAP PPO AND HMO (excluding closed networks with Henry Ford, and Genysis Hospitals)

****WE DO NOT ACCEPT ANY MEDICAID PLANS****

Understanding Insurance Language

Copay
The amount an insured person is expected to pay for a medical expense at the time of the visit.
Coinsurance
More generally, a sharing of risk between the insurer and the insured. Also called copay.
Maximum Benefit
An annual maximum benefit amount is the maximum dollar amount that an insurer has to pay for all healthcare services for the insured during a year.
Deductible
A portion of a claim to be paid by the insured before any payment is made by the insurer.
Coordination of Benefits
Benefits under one plan are coordinated with benefits from another insurance plan (that covers the same benefits), so payments won't be duplicated. All families must submit COB information annually, if using benefits, in order to expedite the claims paying process.

For any questions regarding your insurance please contact our office.
Please check with your insurance company for benefit coverage.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR DR. ANNETTE LACASSE, D.O. PC.

Dear Patient:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

INTRODUCTION

At Dr. Annette LaCasse, D.O. P.C., we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your patient protected health information. This notice is effective April 14th. 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit Dr. Annette LaCasse, D.O. P.C., a record of your visit is made. Typically, this record contains information about your visit including your patient examination, diagnosis, test results, and treatment as well as other information. Your chart often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication with the health, professionals involved in your care.
- Legal document outlining and describing the care you received.
- A tool that you or another payer (your insurance company) will use to verify that services billed was actually provided.
- An education tool for medical health providers. A source for medical research.
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards.
- A source of data for planning and/or marketing.
- A tool we can reference to ensure the highest quality of care and patient satisfaction.

Understanding what is **in** your record and how your health information is used helps you to insure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of the information to other individuals.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR DR. ANNETTE LACASSE, D.O. PC.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and receive a copy of your protected health information at our standard charge for copying.
- The right to appoint a personal representative to receive communication regarding your condition and care. (Personal representative for minor patient will be assumed to be parent or legal guardian unless notified otherwise.)
- The right to amend or submit corrections to protected health information.
- The right to receive an accounting of how and to whom your protected health information had been disclosed.
- The right to receive a printed copy of this notice.

OUR RESPONSIBILITIES

Dr. Annette LaCasse, D.O. P.C. is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to requested restrictions.
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reasons for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR DR. ANNETTE LACASSE, D.O. PC.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your information for treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment: Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations: Your health information may be used as necessary to support the day-to-day activities and management of Dr. Annette LaCasse, D.O. P.C. For example: information on the services that you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates: In some instances, we have contracted separate entities to provide service for us. These "associates" require your health information in order to accomplish the task that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family: There are times when a parent or guardian of a minor cannot view or receive a patient medical record. Michigan law provides for the confidential treatment of a minor upon that minor's request for sexuality matters, contraception, sexually transmitted diseases, mental health concerns and substance-use disorders, among other conditions.

Research/Teaching/Training: We may use your information for the purpose of research, teaching, and training.

Healthcare Oversight: Federal law requires us to release your patient information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public Health Reporting: Your patient health information may be disclosed to public health agencies as required by law.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR DR. ANNETTE LACASSE, D.O. PC.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

Law Enforcement: Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

In Connection with Judicial and Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of the court or administrative tribunal as expressly authorized by such order or in response to a signed authorization (in a format approved by the Michigan Court Administrator).

For Worker's Compensation: The practice may release your health information to comply with worker's compensation laws or similar programs.

Other uses and disclosures: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or privacy practices of Dr. Annette LaCasse, D.O. P.C. please contact:

OFFICE MANAGER
Dr. Annette LaCasse, D.O. P.C.
8906 Commerce Road, Suite 5 Commerce, MI. 48382
(248) 363-5555

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official or, you may file a complaint with the Office for Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F, HHH Building
Washington, D.C. 20201

Annette C. LaCasse, D.O., P.C.≈ 8906 Commerce Road, Suite 5 ≈ Commerce Twp., MI 48382

HIPAA Medical Information Release Form

Name (print) ________________________________ Date of birth ______________

I understand that at any time I am entitled to receive a copy of my medical records and health information from Dr. Annette LaCasse.

The office staff will be happy to provide a copy of this information.

Medical records release signature: _______________________________________
Date: ________________________

Release of Information

I authorize the release of information including diagnosis, examination records, reports and claims information to:

□ Primary Care physician ___________________________

Address _____________________________________

Phone (____) - ______________

□ Spouse _______________________________________

□ Child ____

□ Other ____

Messages

I authorize the office of Dr. Annette C. LaCasse to send appointment reminders to me on my provided cell phone number or email.

I understand that the office of Dr. Annette C. LaCasse may bill the insurance company for any procedures/surgeries rendered.

I authorize the release of any medical information necessary to process these claims.

I will be responsible for any unpaid balances.

*This release of information will remain in effect until terminated by me in writing *

Signed ____ Date ________________

Witness ____ Date ________________

Patient Questionnaire

In order to serve your needs to the fullest, please circle the following topics you would like to discuss or would like further information on.

Skin Cancer Information

Botox

Restylane, Perlane, Juvederm, Radiesse, and Other Fillers for Wrinkles and Lines

Laser Resurfacing & Photo rejuvenation

Psoriasis / Eczema

Lesion Removal

Vein Treatments

Scar Treatments

We offer a complimentary consultation for the following services. Please complete if you would like to schedule a consultation with an Aesthetician.

Microdermabrasion

Chemical Peels