Cape Integrative Care- Medical Weight Loss & Family Practice

New Patient Demographics

Patient Name: _____ Date of Birth: _____

Social Security: _____ Gender: o Male o Female

Address: _____ City: _____ State: _____ Zip:_____

Please check which phone number we can reach you at and leave a message. oHome Phone: _____

oWork Phone: _____ oCell Phone: _____

Email Address: _____

Would you like to participate in our Patient Portal? o Yes o No

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Employer Name: _____ Phone Number: _____

Pharmacy Name: _____ City: _____ State: _____

Mail Order Pharmacy Name: _____ Phone Number: _____

I grant permission to view my prescription history from external sources: o Yes o No

Insurance Information:

oCommercial oMedicare oMedicaid oWorker's Compensation oNone oOther: _____

Primary Insurance: _____Policy # _____ Group # _____

Policy Holder Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

oCommercial oMedicare oMedicaid oWorker's Compensation oNo Fault oOther: _____

Secondary Insurance: _____Policy # _____ Group # _____

Policy Holder Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, ADVANCED BENEFICIARY NOTICE I hereby authorize Cape Integrative Care to apply for benefits on my behalf for covered services. I request that payment from my insurance company be made directly to Cape Integrative Care-Medical Weight Loss & Family Practice. I certify that the information I have reported with regard to my insurance coverage is correct. This authorization may be revoked by either myself or my insurance company at any time in writing. If my insurance company denies payment for services provided by Cape Integrative Care-Medical Weight Loss & Family Practice, I authorize Cape Integrative Care-Medical Weight Loss & Family Practice to initiate an internal appeal, external appeal, and/or arbitration of the denied claim(s) on my behalf. I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. Please be advised that you will be responsible for any balance, in which your plan indicates is your responsibility, on their explanation of benefits EOB form, including, but not limited to non covered and not medically necessary services, All patients will be responsible for their copay, co-insurance and deductible. Should you receive payment directly from your insurance carrier, please forward it to our billing department.

Signature: _____ Date: _____

(Revised 12/04/18)

Cape Integrative Care- Medical Weight Loss & Family Practice

Authorization to Release Medical Records

_____ _____ _____ _____

Printed Name | Patient's Social Security Number | Date of Birth | Today's Date

Address_____

Street Address | City | State | Zip Code | Phone

_____ _____

Signature of Patient or Patient's Representative | Relationship of Representative to Patient

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED.

I hereby authorize the use and disclosure (release) of my Medical Record information:

From: _____

_____

_____

To: Cape Integrative Care- Medical Weight Loss & Family Practice

2441 Myra Drive Cape Girardeau, MO 63703

Phone: 573-803-0919 Fax: 573-818-2508

The information to be released includes:

Entire Medical Record_____ Other_____

The Medical Record Information will be used and/or disclosed for the following purposes:

At the request of the individual_____ Changing Primary Care Physician_____ Changing/seeing Specialist _____

Other (write purpose here)_____

I acknowledge and agree that the term Medical Record information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing, and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

Please **exclude** the following information, if it is part of my Medical Record information *(Check any or all you want excluded from this authorization for use or disclosure):*

__ Chemical Dependency/Substance Abuse __ Psychiatric/psychological conditions __Sexually Transmitted Diseases

__Alcohol __ Drugs __ N/A

I understand that this Authorization shall remain in effect for a period of 90 days. I further understand that I may revoke this Authorization at any time by notifying Cape Integrative Care- Medical Weight Loss & Family Practice in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Cape Integrative Care-Medical Weight Loss & Family Practice before receiving my revocation. I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request. I also understand I have the option to "opt-out" of receiving communications from my provider should I choose to do so as long as I provide them with the request in writing.

Cape Integrative Care- Medical Weight Loss & Family Practice

Financial Policy

Thank you for choosing Cape Integrative Care as your healthcare provider. We realize that the cost of healthcare is a concern for our patients and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Carefully review the following information and please ask if you have any questions about our fees, policies, or your responsibilities.

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes-name, address, phone, insurance coverage, etc.- you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the immediate transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage and Benefits: Your health insurance coverage is a contract between you and your health insurance carrier. **Patients are responsible for understanding their health insurance coverage(s) and benefits**. There may be limitations and exclusions to coverage. **You are responsible for any charges not covered by your plan.**

Insurance Accounts: We ask that you present your insurance card at **every visit**. If you fail to provide us with the correct insurance information at each visit a waiver must be signed and you may be responsible for payment for all services provided.

- Co-payments are due at the time of service, as it is a requirement placed on you by your insurance carrier. Please help us by paying your co-payment at each visit.

- If your insurance company requires you to pick a Primary Care Physician (PCP) one of our physicians must be the PCP listed on your insurance card.

- We will file claims to the insurance companies we contract with, provided that you authorize the "assignment of benefits" for payment directly to our practice. For plans that we participate in, the practice will accept payment based on contractual agreements. You agree to pay any portion of charges not covered by insurance.

- For insurance plans we do not contract with, we will file claims as a courtesy, provided that you authorize the "assignment of benefits" for payment directly to our practice. If your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance information. If a patient is able to provide valid insurance information **within 30 days of the original date** of service a claim will be filed with the insurance carrier. If the insurance carrier issues payment for services rendered the patient will be issued a refund based upon the insurance payment. ***Self-pay patients are responsible for paying 100% of charges at the time services are rendered.***

Worker's Compensation and Motor Vehicle Accident: In the case of a worker's compensation injury, motor vehicle accident and/or other third party liability you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier **PRIOR** to your visit. Failure to provide worker's compensation, motor vehicle accident and/or other third party liability information **within 30 days of the date of service** may result in any unpaid balances transferring to patient responsibility. ***Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party.***

Statements: A statement will be sent to you once a balance becomes patient responsibility and will continue every 30 days thereafter. Unless you notify our office within 30 days of receiving your statement that you dispute the validity of the balance or any portion thereof, we will assume the balance is correct and valid.

Financial Policy

Collection of Outstanding Balances: All outstanding balances shall be due within 14 days unless prior monthly payment arrangements have been made in writing. Balances that remain outstanding after 90 days or more may be referred to an outside collection agency/attorney and may result in termination of medical care. If your account is referred to an outside collection agency/attorney you may be responsible for paying any incurred collection agency/attorney's fees.

Types of Payments: Our practice accepts Debit, Visa, Mastercard, American Express, and Discover. Cash or money orders are also acceptable methods of payment.

Missed Appointments: It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled visit. If speaking to you is not possible for any reason, we attempt to leave a reminder message on an answering machine or voice mail. Your failure to appear for a scheduled appointment or to cancel an appointment **at least 24 hours prior to the visit** may result in a missed appointment fee. This policy is aimed at minimizing waiting time and ensuring availability of medical care for all of our patients. We recognize the fact that there may be circumstances which may not permit you to give 24 hours prior notice but such occurrences are exceptionally rare and shall be considered on a case by case basis.

Treatment of Minors: The parent(s) or legal guardian(s) is responsible for full payment and will receive the billing statements. A signed release will be required to treat unaccompanied minors.

Miscellaneous Fees: Certain services (e.g. family conferences, completing forms, producing narrative reports, personal letters, etc) may entail additional fees not covered by insurance. Payment in full is expected at the time such services are rendered.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

_____ _____

Patient Printed Name Patient Date of Birth

_____ _____

Patient/Responsible Party Signature Date

(Revised 12/04/18)

Cape Integrative Care- Medical Weight Loss & Family Practice

HIPPA Notice of Privacy Practice

Since 1996 certain laws have been enforced regarding medical record privacy (Health Insurance Portability and Accountability Act) or HIPPA. Under the law, we are now required to notify you of this, so here is a short version of these regulations for your convenience. The full Practice Privacy Policy and Assignment of Benefits Agreement is available here for you to read or you can ask for your own copy.

This Notice of Privacy Practice describes the ways we are allowed by law to use your protected information (medical records) or PHI to carry out treatment, payment, and other health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. We are required to abide by these privacy rules.

According to privacy laws, your provider will use your PHI as he/she has always done for treatment, payment, or other health care operations. In addition we may also disclose you PHI from time to time to other providers or health care providers who become involved in taking care of you. Your PHI will be used, as needed, in order for us to obtain payment for our services. Front desk sign in sheets will be used where you will be asked to sign your name and we will call you by name in the waiting room when your provider is ready to see you. We may also use your PHI when necessary to contact you concerning your appointment. We will share your PHI with business associates who perform services for us, including billing services or transcribing services. They are also required to maintain confidentiality.

Your PHI could be used to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you. Other uses or disclosures will be made only with your written authorization, unless otherwise allowed or required by law. You may revoke this authorization at any time in writing.

Unless you object, we may reveal (with your signed consent) to a member of your family, close friend, or other person you choose, parts of your PHI that relate to that person's involvement in your health care. If you are unable to agree or object to this, as in an emergency, your provider will try to obtain your consent as soon as possible. Your PHI may be disclosed to a public health agency or law enforcement as needed to protect you or others. Your PHI may be disclosed by us in order to comply with workman's compensation laws. If you are an inmate, we may disclose necessary information to the staff of the institution.

You have the right to inspect and copy your PHI except for certain federal law limitations. You may also ask us not to disclose your PHI for purposes of treatment, payment or health care operations, also that it not be disclosed to family members. This must be specific and in writing. However, you provider is not required to agree to such restrictions if he/she believes it is not in your best interest. You may ask for your PHI to be amended. You also have the right to know whom we have revealed your information if it is other than for treatment, payment, or healthcare operations.

You have the right to a paper copy of this notice upon request. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing such a complaint.

By signing this form, you authorize all medical service sources and healthcare providers to use and/or disclose the PHI for treatment and care. In addition, you authorize the disclose of information regarding billing, condition, treatment, and prognosis to the following individuals, all of whom collaborate under Cape Integrative Care- Medical Weight Loss & Family Practice: Ashley Uchtman, Holistic Provider; Kendrick Morris, Healthcare Provider; Debbie Evans, Healthcare Provider; Laura Murphy, Healthcare Provider; Karen Graham, Healthcare Provider, Robert Bieser, Healthcare Provider; Susan Anglin, Facial Specialist

Individual(s) listed below are authorized to receive medical information:

_____

_____

_____

Signature_____ Date_____

(Revised 12/04/18)

PATIENT INTAKE FORM
LightPod Neo™ Aesthetic Laser Treatment

NAME: _____ DATE: _____

AGE: _____ SEX: _____ HAIR COLOR: _____

SKIN TYPE (CIRCLE ONE): I II III IV V VI

ALLERGIES: _____

PRESENT MEDICATIONS: (Accutane, Antiviral, Photosensitizers, Other):

_____

PRESENT OR PAST MEDICAL CONDITIONS:

_____

HISTORY OF KELOIDS/HYPERTROPHIC SCARS:

_____

ANY OTHER DERMATOLOGIC OR SKIN CONDITIONS:

_____

HISTORY OF PCOS, OR OTHER HORMONAL CONDITIONS:

_____

PREVIOUS LASER TREATMENTS (Laser Type, Procedure, and any Complications):

_____

_____

MOST RECENT DATE OF: Waxing _____ Plucking _____ Electrolysis _____

OTHER INFORMATION:

_____

_____

_____

Australian Government
Australian Radiation Protection and Nuclear Safety Agency

Fitzpatrick Skin Type

The most commonly used scheme to classify a person's skin type by their response to sun exposure in terms of the degree of burning and tanning was developed by Thomas B. Fitzpatrick*, MD, PhD. Examples are given below.

* Fitzpatrick, T.B. (1988) The validity and practicality of sun reactive skin types I through VI. Arch Dermatol 124; 869-871.

Eye colour

0. Light colours
1. Blue, gray or green
2. Dark
3. Brown
4. Black

Natural hair colour

0. Sandy red
1. Blond
2. Chestnut or dark blond
3. Brown
4. Black

Your skin colour (unexposed areas)

0. Reddish
1. Pale
2. Beige or olive
3. Brown
4. Dark brown

Freckles (unexposed areas)

0. Many
1. Several
2. Few
3. Rare
4. None

If you stay in the sun too long?

0. Painful blisters, peeling
1. Mild blisters, peeling
2. Burn, mild peeling
3. Rare
4. No burning

Do you turn brown?

0. Never
1. Seldom
2. Sometimes
3. Often
4. Always

How brown do you get?

0. Never
1. Light tan
2. Medium tan
3. Dark tan
4. Deep dark

Is your face sensitive to the sun?

0. Very sensitive
1. Sensitive
2. Sometimes
3. Resistant
4. Never have a problem

How often do you tan?

0. Never
1. Seldom
2. Sometimes
3. Often
4. Always

When was your last tan?

0. +3 months ago
1. 2–3 months ago
2. 1–2 months ago
3. Weeks ago
4. Days

Score		
0–6	Skin Type I	Always burns, never tans (pale white skin)
7–13	Skin Type II	Always burns easily, tans minimally (white skin)
14–20	Skin Type III	Burns moderately, tans uniformly (light brown skin)
21–27	Skin Type IV	Burns minimally, always tans well (moderate brown skin)
28–34	Skin Type V	Rarely burns, tans profusely (dark brown skin)
35+	Skin Type VI	Never burns (deeply pigmented dark brown to black skin)






Images sourced from iStockphoto

* The information published here is not intended to take the place of medical advice. Please seek advice from a qualified

INFORMED CONSENT FOR
Nd:YAG 1064NM LASER PROCEDURES

I, _____, have given _____ permission to
(Patient's name) **(Practitioner)**
perform Nd:YAG laser procedures on my _____ .
(area to be treated)

The LightPod Neo® (Nd:YAG 1064nm) laser is FDA approved for a variety of procedures including vein treatment, acne and scar revision. This form is designed to give you the information you need to make an informed choice of whether or not to undergo Nd:YAG laser treatment. If you have any questions, please do not hesitate to ask. Although the laser treatment is effective in most cases, no guarantee can be made that a specific patient will benefit from the treatment.

The laser emits an intense beam of light that is absorbed in specific body tissues within the skin, and depending upon the type of procedure, several treatments may be required at intervals specified by the physician.

Some of the possible complications of Nd:YAG laser treatment are:

1. Discomfort – The procedure is done so precisely that surrounding tissue is minimally affected; the patient may experience a mild sensation of pain in the treated areas. Some degree of skin flushing may occur, but it typically resolves within several hours.
   Initials_____

2. Scarring – There is a small chance of scarring, including hypertrophic scars, or very rarely, keloid scars. Keloid scars are very heavy raised scar formations. To minimize chances of scarring, it is important that you follow all postoperative instructions carefully. It is important that any prior history of unfavorable healing be reported.
   Initials_____

3. Pigmented changes – The treated area may heal with lighter or darker pigmentation. This occurs more often in darker pigmented skin and following exposure of the area to the sun. It is recommended that you protect yourself from any sun exposure for at least three months following treatment. Hyperpigmentation usually fades in three to six months. However, pigment change can be permanent.
   Initials_____

4. HSV Reactivation – The patient agrees to notify the physician if he/she has any history of Herpes viral infections, as the laser procedure may cause it to reactivate.
   Initials_____

5. Lack of Treatment Response – There is a possibility that the targeted hairs, veins or other treated areas will not respond to the treatment. This is often a function of the specific body chemistry of the patient, including relative pigmentation and light absorption characteristics of the patient's various body tissues.

Initials_____

6. Eye Exposure – There is also the risk of harmful eye exposure to laser surgery. Safeguards should be provided by the laser practitioner. It is important that you keep your eyes closed and have protective eye wear at all times during the laser treatment.

Initials_____

7. Photographs – I consent to be photographed before, during, and after the treatment and that these photographs may be published by the above practitioner or Aerolase Corporation in scientific journals or for scientific or marketing reasons.

Initials_____

Additional risks and alternatives:

_____

_____

_____

I certify that I have read or have had read to me, the content of this form. I understand the risks and alternatives involved in this procedure. I have had the opportunity to ask any questions that I had and all of my questions have been answered.

Signed: _____ Date: _____ Time: _____

(Patient or person authorized to consent for patient)

Witness: _____ Date: _____ Time: _____

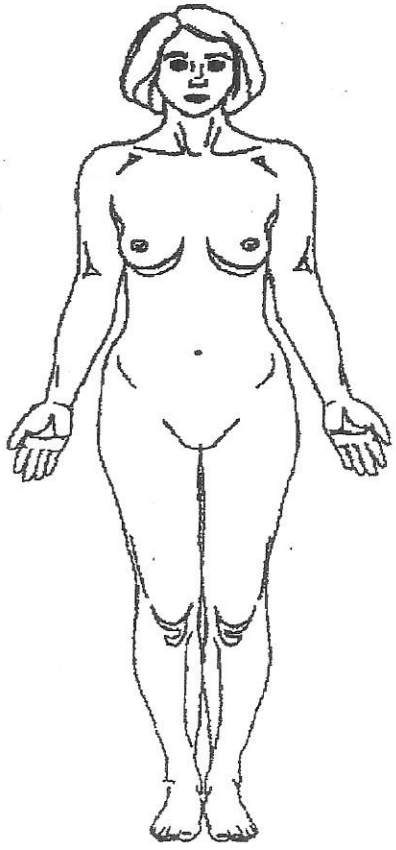
Aerolase Treatment Sheet

Client/Patient Name: _____

Skin Type: I II III IV V VI

Consent Form Signed? _____

Date	Procedure (see below)	Anatomical Site Treated	Spot Size	Fluence	Pulse Width	# of Pulses or Passes	Comments	Clinician Initials



*** Procedures:**

AC = Acne Clearance
AN = Angiomas
CL = Cutaneous Lesions
HR = Hair Removal
LSR = Laser Skin Resurfacing
PR = Photorejuvenation
PS = Pigmented Spots
RO = Rosacea
SR = Scar Revision
SV = Spider Veins
TR = Tattoo Removal

aerolase
compact laser technology

PATIENT TREATMENT CONTROL SHEET
LightPod Aesthetic Laser Treatments

NAME: _____ DATE: _____

CONDITIONS TREATED: _____

NUMBER OF **LIGHTPOD NEO** LASER TREATMENT SESSIONS PLANNED: _____

COST PER SESSION OF **LIGHTPOD NEO** LASER TREATMENT: _____

TOTAL COST OF **LIGHTPOD NEO** LASER TREATMENTS: _____

_____

NUMBER OF **LIGHTPOD ERA** LASER TREATMENT SESSIONS PLANNED: _____

COST PER SESSION OF **LIGHTPOD ERA** LASER TREATMENT: _____

TOTAL COST OF **LIGHTPOD ERA** LASER TREATMENTS: _____

CONCURRENT MODALITIES USED (filler/toxin, microdermabrasion, peels etc.):

MODALITY: _____ COST PER SESSION: _____ TOTAL COST: _____

MODALITY: _____ COST PER SESSION: _____ TOTAL COST: _____

MODALITY: _____ COST PER SESSION: _____ TOTAL COST: _____

MODALITY: _____ COST PER SESSION: _____ TOTAL COST: _____

TOTAL COST OF **ALL** TREATMENTS: _____

PATIENT'S PRINTED NAME: _____ DATE: _____

PATIENT'S SIGNATURE: _____

aerolase®
reinventing medical lasers