Mary Lee Amerian, M.D., FAAD
Diplomate American Board of Dermatology
Assistant Clinical Professor, UCLA

George Anterasian, M.D.
Diplomate American Board of Head and Neck Surgery

Date _____

Patient Name _____
LAST FIRST MIDDLE

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Male ☐ Female

Age _____ Date of Birth ____/____/____ Place of Birth _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Drivers License No. _____ Social Security No. (Protected by HIPAA) _____

E-mail Address _____ ☐ Would you like to receive our newsletter? It contains information about skin care and special discounts.

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Parent or Spouse _____

Parent or Spouse Employer _____

Business Address _____ Business Phone _____

Nearest Relative or Friend Not Living With You _____

Address _____

City _____ State _____ Zip _____ Phone _____

Referred by _____ MAY WE THANK THE PERSON THAT REFERRED YOU?

Responsible Party (If under 18) _____ ☐YES ☐NO

I, the undersigned (patient or legal guardian), authorize medical treatment by Dr. Amerian and/or Dr. Anterasian and assume financial responsibility.

Signature _____

PERMISSION TO LEAVE CONFIDENTIAL MEDICAL MESSAGE ON VOICEMAIL?

☐YES ☐NO

PERMISSION TO COMMUNICATE VIA EMAIL?

☐ YES ☐ NO

PERMISSION TO DELIVER RESULTS VIA EMAIL?

☐ YES ☐ NO

Preferred Phone Number:_____ Preferred Pharmacy:_____

Have You Ever Had Any Allergic Reaction or Side Effect From Any Medication: ❑ Yes ❑ No

If Yes, Please Specify: _____

List Current Medications (including birth control pills) _____

List Your Current Facial Products _____

_____

Have You Ever Had Any Serious Medical or Surgical Problems: ❑ Yes ❑ No

If Yes, Please Specify: _____

Tobacco Use ❑ Yes ❑ No

Have You Ever Had The Following:

	Yes	No
Ulcer	❑	❑
High Blood Pressure	❑	❑
Diabetes	❑	❑
Glaucoma	❑	❑
Hay Fever	❑	❑
Hives	❑	❑
Asthma	❑	❑
Chemotherapy	❑	❑
Dermabrasion	❑	❑
Laser	❑	❑
Chemical Peel	❑	❑
**Skin Problems	❑	❑
**HIV / Hepatitis	❑	❑

**If Yes, Please Specify _____

_____

_____

Have Any of Your Blood Relations Had Any Skin Problems? ❑ Yes ❑ No

If Yes, Please Specify Relationship and Problem _____

_____

Have Any of Your Blood Relations Had Hay Fever or Asthma? ❑ Yes ❑ No

If Yes, Please Specify Relationship _____

_____

Would You Be Interested In More Information On Our Cosmetic Skin Care And Laser Services?

(e.g. large pores, wrinkles, skin texture, small veins, discoloration) _____

_____

Santa Monica Laser and Skin Care Center

Mary Lee Amerian, MD
George Anterasian, MD

Cancellation Policy

We are committed to providing all of our patients with exceptional care in a timely manner. For this reason, we have instituted a 24-hour cancellation policy for all appointments.

The office needs to be notified **24 hours** prior to the appointment date in order to avoid a cancellation or no-show fee of $**100**.

We appreciate your understanding and cooperation.

Patient Consent

I have read this policy and understand that I need to provide at least 24 hours notice when rescheduling or cancelling an appointment. If I fail to contact the office at least 24 hours in advance, I will be charged the $100 cancellation fee.

Name: _____

Signature: _____ Date: _____

For Office Use Only

Credit Card Information

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Number: _____ Expiration: _____

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Mary Lee Amerian, MD

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____ (Patient's Name) understand that as part of my health care, Mary Lee Amerian, MD originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Mary Lee Amerian, MD **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review Mary Lee Amerian, MD Notice *of* Privacy Practices prior to signing this acknowledgement;
- that Mary Lee Amerian, MD reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature *of* Individual or Legal Representative Witness ....

Printed Name of Individual or Legal Representative Witness.....

Date: .....

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

_____

_____

_____ _____

Date

Privacy Official

Sara Celnik

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this faciliy's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- this facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness .....

X **Printed Name of Patient or Legal Representative Witness** .....

Date: .....

Mary Lee Amerian, MD
George Anterasian, MD

Santa Monica Laser and Skin Care Center

Patient Name: Date:

As we are a full service dermatology practice, please let us know if you would like to discuss any of the following with your physician.

- ❑ Facial Wrinkles and Lines
- ❑ Facial Drooping and Facial Skin Laxity
- ❑ Neck Wrinkles
- ❑ Chest Skin
- ❑ Brown Spots/Age Spots/Freckles
- ❑ Facial Redness
- ❑ Aging Eyelids/Under Eye Puffiness
- ❑ Thin Lips
- ❑ Excessive Body Fat and/or Body Shape
- ❑ Unwanted Hair
- ❑ None of these items concern me