Integrative Dermatology & Laser Spa

Vindhya L Veerula MD, FAAD

(Fort Wayne Integrative Dermatology, Veerula MD,LLC)

www.drvskin.com

Patient Information:

FULL NAME: First _____ Last _____ MI _____ Marital Status: S M D W

SOC SEC NUMBER: _____ - _____ - _____ DATE OF BIRTH: _____ / _____ / _____

EMPLOYER: _____ How did you hear about us? (facebook, friend, prior patient, other) _____

ETHNICITY: NON-HISPANIC _____ HISPANIC _____ PREF LANGUAGE: _____ RACE _____ GENDER: M F

Would you like a text or phone call reminder for future appointments (please circle one): Text / Phone Call

+ADDRESS: _____ HOME PHONE: _____

_____ WORK PHONE: _____

_____ CELL / MOBILE PHONE: _____

EMAIL ADDRESS: _____ IS IT OK TO EMAIL YOU? Y N

Would you like to receive our newsletter? Y N. PREFERRED PHARMACY _____
(NAME, ADDRESS, PH)
_____

PROVIDER INFORMATION:

PRIMARY CARE PHYSICIAN: _____ REFERRING PHYSICIAN: _____

Insurance Information (Please present hard copy of insurance card)

Guarantor Information (Please fill out if patient is not primary on insurance):

GUARANTOR NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS:_____ Date of Birth:_____

Emergency Contact Information:

NAME: _____

ADDRESS:_____ MOBILE _____

PHONE: _____ RELATIONSHIP TO PATIENT: _____

Please Initial the following :

AUTHORIZATION TO RELEASE MEDICAL INFORMATION & ASSIGNMENT OF INSURANCE BENEFIT

X_____I authorize the release of any medical information necessary to process my insurance claim(s) and assign all medical and/or surgical benefits including major medical benefits, FWIM & VeerulaMD,LLC & Vindhya Veerula, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. Even though I have provided all of my insurance information, I understand that I may be financially responsible for any balance not covered by my insurance. I agree to provide my most current insurance information and if any bills are not paid by insurance because of outdated or inaccurate information, I agree to pay my entire bill in full – even though the bill might have been paid by insurance had I provided the correct information. I understand that holistic treatments are not a substitute for medical diagnosis and treatment, and no medical claims are made regarding these treatments. (March 1, 2018)

FINANCIAL AGREEMENT

X_____All FWIM & VeerulaMD,LLC's account balances are due at the time of service. I understand and agree that, (regardless of insurance coverage), I am ultimately responsible for any professional service rendered. I certify that this information is true & correct to my best knowledge. I will notify you of any changes in my insurance coverage, address, or health status. I accept this statement as notice from you that my insurance plan may not pay for any service that you provide to me because the service or procedure may not be covered by the plan or may not be considered medically necessary by the plan. I agree that all services and procedures that I receive from you have been requested by me with full knowledge that my insurance plan may not cover them.

CREDIT CARD CHARGES:

X_____ Due to the rising costs of credit card fees, I understand that a 2% fee will be added to any and all credit card fees, and 1% for debit cards fees. There is no additional fee for payments paid with checks or cash.

COSMETIC TREATMENTS

X_____I also agree that certain treatments are not covered by insurance and are considered cosmetic. These will not be billed to insurance. These require payment IN FULL at the time of, or prior to the procedure. I understand that Dr. Veerula sends all specimens to pathology for verification, and this fee is separate from the removal fee.

LATE PAYMENTS

X_____All past-due account balances may be assessed a LATE PAYMENT FEE equal to 18% per annum on the delinquent balance. A LATE PAYMENT FEE can be avoided by paying the account balance within 30 days of the mailing of the patient statement. Subject to such limitation as may be imposed by applicable law, if I have not made payment on my account as required, my account may be sent to an attorney or collection agency for collection, I will pay the reasonable fees of such attorney or collection agency, and all court costs to the extent provided by law as well as my total outstanding bill. No waiver by Fort Wayne Integrative Medicine or FWIM & VeerulaMD,LLC or any default hereunder shall constitute a waiver of any other default. The construction and enforcement of this Agreement shall be governed by the State of Indiana. Any provision of this agreement that may be prohibited by law shall be ineffective only to the extent of such prohibition. From time to time, FWIM & VeerulaMD,LLC may amend this Agreement by giving of such notice, if any, as may be required by applicable law. FWIM & VeerulaMD,LLC may assign the Agreement, or it's right hereunder, without notice to me.

NO SHOW/CANCELLATION POLICY:

When you make an appointment, we are reserving time in our clinician's schedule that is no longer available to other patients. If you are unable to make it to an appointment, VeerulaMD,LLC requires that you cancel (or re-schedule) your appointment at least 24 hours in advance (excluding weekends and holidays). If you cancel an appointment with less than 24-hour notice or fail to appear in a timely fashion for an appointment, VeerulaMD,LLC will charge the patient $100.00. This applies to new patients as well (government plans are excluded, unless we do not accept your plan). Failure to show for your appointments (or violation of this cancellation policy) on two or more than three consecutive occasions can be grounds for discharge from the clinic . *X _____ If you fail to adequately cancel 3 times, you will be subject to not being accepted for further treatment.*

Note that the cancellation fee may be waived in special circumstances, determined on an individual basis (eg: medical emergency- patients may be asked to provide documentation for the same).

CONSENT TO CARE

X_____ I request and give consent to Dr.Veerula, the nurse practitioners, their associates and assistants who may provide me medical care to perform such medical-surgical care, tests, procedures, and other necessary services as well as provide drugs and supplies as they consider necessary or beneficial for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. In addition, I understand there may be adverse effects or complications from some treatments/procedures/drugs, etc.

Check all that apply: I agree to be contacted at: _____Home _____Work _____Cell _____EMAIL

Signature of Responsible Party: _____ Date_____

FOR MEDICARE PATIENT ONLY:

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Vindhya L Veerula, MD, FWIM, & VeerulaMD,LLC., including physician, nursing or lab services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits for related services.

Signature _____Date_____

HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

Date: Month _____ Day _____ Year _____

VeerulaMD,LLC's "Notice of Privacy Practices" has been offered to me. It is available from the front desk of the VeerulaMD,LLC as well as on the website (*WWW.FWIMED.COM*) I understand I have the right to review the "Notice of Privacy Practices" prior to signing this document. By signing this document, I acknowledge my receipt of and my agreement with and understanding of the above mentioned privacy practices.

Fort Wayne Integrative Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

Updated "Notice of Privacy Practices" is available at the front desk or on the website.

_____

Printed Name of Patient OR Printed Name of Patient Representative

_____

Signature of Patient OR Signature of Patient Representative

_____ _____

Patient Date of Birth Description of Personal Reps. Authority

☐ Check if the patient is a minor

I authorize the following individuals to have access to my Protected Health Information (PHI):

Name	Relationship	Date of Birth	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature: _____

For authorization to release PHI to the above listed individuals.

HIPAA email consent VERY IMPORTANT! PLEASE READ!

HIPAA stands for the *Health Insurance Portability and Accountability Act.* HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information. Information stored on our computers is encrypted

Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email

When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA

The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website - http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

OPTION 1 – ALLOW UNENCRYPTED EMAIL
I understand the risks of unencrypted email and do hereby give permission to VeerulaMD,LLC to send me personal health information via unencrypted email. I also understand that if I send an email to VeerulaMD,LLC, then my consent to receive an email response is provided.

Signature_____ Date_____

Printed name (parent or guardian if patient is a minor)_____

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL

____ I do not wish to receive personal health information via email

Signature Date_____ Printed name (parent or guardian if patient is a minor)

Please bring completed form to your visit

Please print email address _____

HISTORY & REVIEW OF SYSTEMS QUESTIONNAIRE:

Reason for visit:

_____

_____R

ate your pain 1-10: _____ How long have you had this? _____

What makes condition better or worse:

_____

_____

_____Does stress make it worse? Y N

What treatments have you tried? _____

_____

PAST MEDICAL & PAST SURGICAL HISTORY:

Have you ever had?

___ Asthma/Hay Fever ____Arthritis ___Bleeding problems ____Diabetes ___Cancer ___Heart Disease
____Hepatitis ___Hormonal conditions ___Hives ____Heart murmur ___ Xray /radiation
____ Eczema ___ Fainting spells ___Pregnancy ____ Back injuries ___Cold Sores/Fever Blisters
___ High blood pressure ___ Tuberculosis ___Autoimmune conditions (lupus, RA, thyroid other)

Please list any other medical history ***(including surgeries):***

_____

_____

_____

Have you had a knee or hip replacement? When? _____

When did you last see a dermatologist? ___ Never ___ 6 months ___1 year ___2 years

Who did you see? _____

List any prior biopsies, excisions, light treatment, chemo cream, botox, fillers, lasers, or peels here:_____

_____

_____

List any oral or topical medications, birth control, and supplements you are currently taking:
LIST MEDICATION, DOSE, & FREQUENCY

_____

_____

_____

Allergies: List allergies to anesthesia, steroids, or antibiotics.

Have you taken oral or IM steroids? Y N How long ago? _____

Do you take NSAIDS (Aspirin, Motrin, Ibuprofen, Excedrin) Y N How much_____

Tylenol Use? _____ how often?_____ Acid blocking drugs (zantac, prilosec,etc? Y N

Pacemaker or defibrillator or spinal implant? Y N Are you pregnant? Y N How many weeks?

Do you need to take preoperative antibiotics before a dental procedure? Y N

Have you taken Accutane Y N How long ago & for how long? _____

Do you form keloids or hypertrophic scars Y N

Do you smoke? YES_____ NO____ How long?_____ Packs per day_____

Do you drink alcohol? YES____ NO____ How many drinks per week?_____

Do you use recreational drugs? YES____ NO____ If yes, what kind?_____

Family History (cancers or skin conditions)_____

SKIN QUESTIONNAIRE:

What skin concerns bother you? ___Wrinkles ___Dark Circles ____Pores ___ Scars

___Red spots ___Brown Spots

___New or changing moles? Where?

Do you choose organic products? Y N Do you use essential oils? Y N

Do you sunbathe? Y N How often? Do you use a tanning booth? Y N How often?

Do you use sunscreen? Y N SPF: History of blistering sunburns? Y N How many?

Have you had an allergic or irritant reaction to skin care products? Please list.

Any pets? _____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? *List below. (Vegan, vegetarian, organic, gluten free, ketogenic, low carb, high fat, none, etc)*

Do you have sensitivities to certain foods? Y N If yes, list food and symptoms:

_____

_____

_____

Do you have any food allergies? Y N If yes, list foods: _____

Are there any foods that you crave or binge on? Y N

If yes, what foods? _____

Do you eat 3 meals a day? Y N If no, how many meals per day do you eat? _____

Any lifestyle or other barriers to healthy eating? Y N

If yes, please explain: _____

Cans of soda per day (regular or diet) _____

Number of glasses of water per day: ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ >8

Stress

Do you feel you have an excessive amount of stress in your life? Y N
Do you feel you can easily handle the stress in your life? Y N
How much stress does each cause on a daily basis: *(Rank on scale of 1-10, 10 being highest)*
Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____

Do you use relaxation techniques? Y N If yes, how often?_____
Which techniques do you use? ___Meditation ___Breathing ___Tai Chi ___Yoga ___Prayer

Other:_____

Have you ever sought counseling? Y N
Have you ever been abused, a victim of crime, or experienced a significant trauma? Y N
What are your hobbies or leisure activities?_____
Do you have any pets or farm animals? Y N If yes, do they live: ___Inside___Outside ___Both
What kind of pet(s):_____

Are you currently having any of the following symptoms? ***If yes, please check the following appropriate boxes***

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain >10 pounds
- ☐ Weight Loss >10 pounds

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ear Ringing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Sputum Production
- ☐ Wheezing

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains with walking
- ☐ Leg Swelling
- ☐ Night Awakening due to trouble Breathing
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting/Stopping urinary Stream
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

Patient's Signature _____ Date _____

Print Name _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize _____ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____
Customer Signature Date

To cancel, you must provide a written request, unless performed in person at the office.
We will charge your card in the case of No Show or <24 hour cancellations.

Standard Patient Photographic Consent Form

- **I hereby consent to the taking of photographs and/or film and sound recordings of me or parts of my body (hereinafter referred to as the "Materials") and grant VeerulaMD, LLC and/or Vindhya Veerula MD and/or their designee (Dr.Veerula) permission to publish, distribute, and otherwise use such Materials in any and all of its publications.**
- **I understand and agree to transfer any and all rights I may have in and to these Materials, and that they will become the property of Dr.Veerula and will not be returned.**
- **I understand that the Materials may be published by Dr.Veerula or a third party such as the American Society for Dermatologic Surgery in any print, visual or electronic media, specifically including, but not limited to, newspapers, magazines, medical journals and textbooks, pamphlets and the Internet, for the purpose of informing the medical profession or the general public about dermatologic surgery and/or dermatologic surgery methods.**
- **I hereby authorize Dr.Veerula to edit, alter, copy, exhibit, publish or distribute these Materials for purposes of publicizing Dr.Veerula's services or programs or for any other lawful purpose including, but not limited to:**

_____Ø Medical purposes related to case.

_____ Ø Scientific purposes, including seminars, medical articles or educational presentations such as the American Society for Dermatologic Surgery Annual Meeting, website or other venue.

_____ Ø Before-and-after photo album (digital or printed) for cosmetic patients to view in office.

_____ Ø Before-and-after photographs and/or digital images to be included in newsletter to be sent to patients.

_____ Ø Before-and-after photographs and/or digital images to be included in our website for cosmetic surgery.