AESTHETIC DERMATOLOGY 6LASER SURGERY
JONITH Y.BREAOON. M.O. S ASSOCIATES
mos W FULTOII MARKET ST. CIIICAGO, IL 60607P# 312 733 2492 F# 312 733 2498 WWIO

PATIENT

aL stName:First Name:.... ...L.-------- ---MI:

0.0.8:/ / Age: __Sex:M/f/_Marital Status: S/ M/DPrefers to be called:_
Address:
City: _ _ _ _ _ _ _ _ _ _ _State: Zip: _

Cell#:Home#:Work#:._

Em_ail:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Occupation: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Employer Name/Address/Phone#:_ _

Prmir ary Care Physlci an{PC:P). ?Ce.Jlh#: _

Referring Physician (if applicable}: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Ph#: _

Referral Source: Insurance/ Zoe Doc/ Patient: _ _ _ _ _ _ _ _ _ _ _ _ _ _ / Other:_

Pharmacy:P_h#: _ _ _ _ _ _ _ _ _ _ _ _ _ _

RBREADON.CDM.

EMERGENCY CONTACT

Con tatcs' Name:Relationship:_
Contact's Phone Number:

In order for clmai s to be billed to insurance. current information must be present at each visit

NOTE: Complete this portion below, ONLY if different from the patient

Insurance Plan:Mer

Group #:_

Policy Holder's Name:D. 0.8://Rel
Policy Holder's Mailing Addres:s ____

City:Stata:

Please only indicate if different frnm patient. who VIII! b!l es p ons rrbel for pa\'ing pationt!iablo charges on our account

Name: 0.0.: B _ / _ / ___

RelaUom1hlp to patient:Contact Ph#: _

Address: _

City:Stite:Zip code:_

I authorire payment for my s ervices to be issuedto the provider and authorire the release of any necessamry edical Information for the purpose of processlng clelms with my insurancecompany, pharmacy requests and autharlzations. and anything pertinent to my care. I permit a copy of this authorization to be used in place of the original.I have complete this fomr to Iha bast of my knowledge and knowall information provided to be true. If I have providedany false dooumentatlon, Aesthetic Dermatology Ir laser Surgery has the right ll collect allfees prior to my office visit and I will he se:en esaSett-Pay patient for my entirety of treatment at Aesthetic Dermatology 6laser Surgery. I also understand that if I am m as a Sett-Paypatient or have procedurews hich are considered cosmetic In nature. that I am responsibleto pay for services in full at the time of my office visit.

SIGNATUREOF RESPONSIBLE PARrXf

DATE:

JONITH Y. BREADON, M .D.
1009 W. FULTON MARKET ST., CHICAGO, IL 60607 P# 312·.733.2498 WWW.DRBREADON.COM

M EDICAL HISTORY

* * * PLEASEPRINT CLEARY** *

What is the reason for your visit today? Date ____,__ ._____ _

Name____Age_ _ _ _ _ DOB _ __,, ._____ _

Preferred Name:_ Preferr ed Pro nouns :_ _ _ _ _ _ _ _ _

How/by whom were you referred to the practice?:_ _

Please list your current medications:

Do you have any know drug aller gies: Yes No

If Yes, please li st medication and reaction type_ _ _

Do you or your relatives have any history of the following diseases?

High Cholesterol Emphysema Asthma
Phlebitis Diabetes Thyroid Disease Kidney Problem s
Chronic Cough Morning Cough Depression
Bladder Problems Stomach Problems Bo"'."e l Problems Hepatit is or Yellow Skin Glaucoma
High Blood Pressure Chest Pain
Arthritis / Join t Deformity Epilepsy/Seizures Fainting
Heart Attack
Other:
Heart Murmur Irregular Heart Beat Pacemaker
Other :

	You	Relative		You	Relative

Other Medical History: _

Please answer the following questions:

Do you sun bathe or do outdoor activities? Yes No

When you are exposed to the sun do you: Burn Burn & Tan or Tan

As a child, did you have a history of sunburns? Yes No Adult hist ory of sunburns? Yes No

Do you use sunscreen? Yes No If yes, do you use it regularly? Yes No What SPF number?

Do you have a history of any skin diseases? Ye s No

If yes, wh_at _

Do you have a history of fever blister or cold sores? Yes No Are you pregnant? Yes No

Have you ever had skin cancer? Yes No If yes, where? _

What type_? _

Has anyone in your family had skin cancer? Yes No M elanoma? Yes No What type? _ _ _ _ _

CONTINUED ON BACK SIDE OF SHEET...

JONITH Y. BREADON, M.D.
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WWW.DRBREADON.COM

Nam _e _ DOB _ ___ ___ _

Do you routinely take aspir in? Yes No
List any ot her disease(s) or cond i tion (s) we should know about: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

List any surgical procedures you have had in the past six months: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Do you smoke? Yes No If yes, how much and for how long?_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
Wha t is y our occup a t ion _? _

What are your hobbies? _

Do you have any ar ti fic ial joint s? Yes No
Do you bleed easily? Ye s No

Health Habits:

How many times a day do you take a bath or shower? _
Do you use ho t, warm or cool wat er in your bath or shower? _
How long are your baths or showers? _
How manyt im es a day do you wash your face? _
What brands of cleanser do you use on your face? _
What brands of cleanser do you use on your body? _
Do you apply moistur izer to your face? Yes No If yes, what brands? _ _ _ _ _ _ _ _ _ _ _ _ _ _
Do you apply moist urize r to yo u r body? Yes No If yes, what brands? _ _ _ _ _ _ _ _ _ _ _ _ _ _

Would you like inform ation on the following?

	Fillers		Nail Disease
	Neuromodu lat or Injections (w r inkle remover)		Chem ical Peels
	Acne Laser Treatm ents		M icrodermabras ion / SilkP eels
	Ski n Care Prod u cts		M icroneedling
	Skin Cancer Remo val		Wart Removal
	Skin Cancer Preven tion		M ole Removal
	Laser Hair Rem o val		Hair Loss
	Varicose/ Spid er Vei n Treatment		Thread Lift s
	CoolScul pti ng (Fat freezing)		Aero lase-Ski n Tight ening
	Ant i-aging Treatme nts		Other:

____
I¾J IEN T'S (OR GUARDIAN'S) SIGNATURE DA TE

OFFICE USE ONLY :

______________________________ ______________
REVIEWED BY DATE

AESTHETIC DERMATOLOGY & LASER SURGERY
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OFFICE AND FINANCIAL POLICIES

Nelcome and thank you for choosing Aesthetic Dermat olog y and Laser Surgery, the office of Dr. Jonlth Breadon & Associat es, for your lermatology care. We are committed to provide you with the highest quali ty med ical care. Please ta ke a moment to review our financial iolicy so that you understandyour responsibi lity regarding the charges for the services rendered to you by this offi ce.

NSURANCE: When making an app oint m ent at our offi ce, it is your responsibility to confirm with your insurance company that the physician s curren tly cont racted with your plan. Our office does not bill outof network (non-contracted) insurance plans. If your plan is out of 1etwor k, you are requ ired to pay in full for your visit at the time services are rendered . Secondary policies will be billed for Medicare Jatients only. In order for us to bill your insurance , you must provideus with a cur rent copy of your medical insurance card, along with all
·equired informat ion at every visit. If you are unable to provide this at the tim e of your appo intm en t, you may reschedul e or pay in full at :he time of service. Whil e providing this service, please remembe r that your insurance company requires you to know your plan's benefit Jolicies including co-payments, the specifics of what your policy covers, and to notify us when your insuranceplan changes, prior to your 3ppoint ment . Each plan has it s own st ipulations regarding the coverage of, and payment for, medical services; therefore, it is extremely :lifficult for us to be aware of the m ultitud e of individual requireme nt s for e ach of our pat ien ts' plans.

I\SSIGNMENT OF BENEFITS: In consideration of t hese med ical services, I hereby assign, transfer and set over to ADLS all my rights, title and interest to medical reimbursement benefit s under my insura nc e policy(s). If my insurance benefi ts are pro vi ded t hr ough Employment Retirement Income Se rv ice Act Pla n, I hereby assign, transfer and set over all my rights, tit le and interest as beneficiary of the ERISA plan to ADLS with regard to my tr eat ment and care wit h ADLS.

PATIENT BALANCE: Statements are billed once a month . If your insurance does not respond to or pay your claim within 45 days, the full balance wi ll become the patient/ gua r antor 's responsibility. All balancesare due upon receipt of your first stat eme nt. Partial payments will not be accepted unless prior payment arrangem ents , appropriat ely based on balance due, have been made. Al l account balances not paid wit hin 30 days will be assessed a billing feeof $10.00 per billing cycle. After three billing cycles, your unpaid balance will be turned over to a collection agency and you will be respons ible for ALL collec t ion agency fees. If your insurance is out of network (ADLS, D r. Janith Y. Breadon & Associates is not con tra cte d), you must pay for your servicesin full at the time of your visit .

CO-PAYMENTS: All ins urance com pa ni es require copays to be co ll ec t ed at t he time of service. Your copay is due at the time of check-in. A
$10 .00 serv ice ch arge will be assessed each time a copay is not paid at the t ime of servic e.

CHECK-IN: We do our best to keep on schedule, so please arrive for your appointment on time. If you arrive more than 15 minutes past your scheduled appointment time, we reserve the right to reschedu le your appointment. On foll ow-up visit s, you will be asked to verify demographic and insurance info rm atio n so that our records remain up-t o-dat e. Please be prepared to pay any past due balance (31+ days) prior to seeing any doctor or physician assistant.

CHECK-OUT : Payment of non-cove red services will be required at thetime of service. For your convenience, we take cash, check, Maste rCard, Visa, Discove r, American Express, and Care Cred it. A $35.00 fee will be assessed on any and all ret urn ed checks.

NON-COVEREDSERVICES: Payment in full for non-covered services is required at your visit. Please come prepared wit h the proper payment for your treatment. Cosmetic pro cedures includ ing, but not limite d to Skin Tag Rem ova l, Varicose Veins, Neuro toxin s (Botox, Dysport, Xeomi n) Fille rs (Sculpt ra , Radiesse, Rest ylane, etc .), Laser Su rgery, Hair Red uction, Phot o-Rej u venat ion, Chem ical Peels, M icro -Derm abrasion treatments are not covered by insurance and claims will not be filed for them. Most cosme ti c services must be paid for by CASH OR CREDIT CARD AND A DEPOSIT MUST BE GIVEN AT TIME OF BOOKING APPOINTMENT (SEE, REQUIRED DEPOSITS FOR SPECIAL SERVICES).

MEDICAL NECESSITY: I und ersta nd that I am respons ible for all charges incurr ed. If my insur ance policy determi nes/denie s my procedure as NOT MEDICALLY NECESSARY, I am re sp on sible fo r payme nt in full.

CONTINUED ON BACK SIDE OF SHEET............

CONSENT FOR TREATM ENT: I acknowledge and underst and that, in presenting myself for tr eatm ent and continuing medical care at Aesthetic Derm atology & Laser Surgery, I author ize and consent to the adminis trat ion and performance of all dermatologic services agreed upon between the doctor and patient and/or guardian , in cluding tests, treatments, use of local ane sthesia and other medications which may be orde red by the physician (and/ or other designated assista nt) and carried out by members of Aesthetic Dermatology & Laser Surg ery.

NO SHOWS AND LATE CANCELLATIONS: We require a 48-hour advance notice if you must cancel your appointment. For your convenience, we offer an automated confirmat ion/ rem inder system th at will call you 48 hours prior to your appointment. Each patient is allowed one NO SHOW without penalty. The second NO SHOW and all subseq u ent NO SHOWS will result in a $25.00 charge to your account.

PATIENTS WITH PAST DELIQUENT ACCOUNTS: *All patients who have had their account assigned to a collection agency are considered delinquent accounts & will be required to pay for services inf ull at the time they are rendered.*

REQUIRED DEPOSITS FOR SPECIAL SERVICES: We do require deposits when booking COSMETIC PROCEDURES. The required deposit amounts for services are listed below:

$50.00 DEPOSIT: l aser Hair Remo val, Ch emical Peels, Photo -Rejuvenation, M icro -Dermabrasion, Sil k Peel and any other NON-COVERED SERVICE performed on our Promotio nal 50% Off Days

$100.00 DEPOSIT: Neurotoxin & Filler Injections, Skin Tag Removal, Varicose Veins

YOU WILL FORFEIT YOUR DEPOSIT IF YOU FAIL TO CANCEL 48 HOURS PRIOR TO YOUR APPOINTMENT TIME. ALL DEPOSITS ARE NON REFUNDABLE, BUT CAN BE TRANSFERRED TOWARDS YOUR ACCOUNT BALAN CE OR HELD AS A DEPOSIT FOR FUTURE COSMETIC APPOINTMENTS.

M INORS : Th e parent(s) or guardian(s) must accompany a minor for the first visit to our office. The parent(s) or guardian(s) are respon sible for providing current insurance informat ion for the minor and/or payment in full for services provided. For follow-up visits, unaccompanied minors must have an authorization form for medical treatment signed by a parent or guardian before treatment ca be rendered.

HOW MAY WE CONTACT YOU?: With this consent, ADLS may call and leavea message at:

M OBILE: Y / N (_)__________________ HOME: Y / N (_ _)____________________ WORK: Y / N (__)_ _ _ _ _ _ _

PAYMENT AGREEMENT FOR ALL PATIENTS OF ADLS: I h e reb y assume full responsibility for and agree to pay all costs, charges and expenses incurred by the patient, to ADLS. I understand and agree that th is understandin g consti t ut es a direct primary and personal undert aking by me and is not condit ion ed or contingent upon payment of any such costs, charges or expenses by an y t hir d p arty. An assignment of bene fit s of any insurance policy or medical reimbursement plan shall not be deemed waiver of the Provider' s righ t to acquire payment directly from the undersigned. The provider expressly reserves the right to require such payment. In the event that this obligation remainsunpaid and requires ref erral for collection, the undersig ned agrees to pay all costs of collections, including, but not limited to reasonable attorney's fees. If the undersign ed is more than one person, every obligation hereunder shall be joint and several.

M Y SIGNATURE BELOW SIGNIFIES THAT I HA VEREAD, UNDERSTAND AND AGREE TO THE OFFICE AND FINANCIAL POLICIES.

Patient Name (PRINTX "....- - - - - - - - - - - - -

Patient Signature : _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date:_ _

W i tness : _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Date:_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

HIPM CONSENT
Aclmowledgement of Notice of Privacy Practices

AESTHETIC DERMATOLOGY & LASER SURGERY, Ja n ith Y. Brcadon, MD

T he Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HI P AA).

Our Notice of Privacy Practices provides informati o n about how Aesthetic Dermato logy and Laser Surgery, J ni th Y Breadon, MD (ADLS) may use and disclose protected health in formatio n (PI-II) a bo ut you to carry out treatmen, t payment and healthcare operations (TPO). You have the right to review out Nolice of Privacy Pract ice at any time. If we change our Notice, you may obtain a revised copy by co ntacting our office.

By sig ning this form, you consent to our use and disclosure of protected health information (PH I) about yo u for trea tment, payment and health care operations (TPO). You have the right to revoke this consent, in writing, signed by you. However, such a revoca tio n shall not a ffec t any disclosures we have alre ad y made in reliance on your prio r consent. ADLS provides this form to comply with the Health Insurance Portability and Acco unt ability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment , payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the op port unity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to.
- The patient may revoke th is Consent in writing at any time and all future disclosures will then cease, those restrictions, except in certain limited instances.

With my co nsent, ADLS may call my home or other designated locat io n and leave a message on a voice mail or in person in refere nce to any items that assist the practice in carrying out hec1lth ca re operations, such as appointment reminders, insuran ce items and any call pertaining to my clinical care, including laboratory results among others.

Wilh my co nse nt, ADLS may mail to my home or other designated location any ite ms that assist the praclice in carrying out heath care operations, such as patient state men ts, collection lett e rs and any o ther co rr es po nde nce or related material.

Howeve r, the practice is not required to agree to my req uested restrictions, but if it doe s, it is bound by thi s agree ment.

By s igning this form, I am consenting to ADLS's use and disclos u re of my PHI to cc1ny out T PO.

I may revoke my consent in writing except to the exte nt that the practice has aJread y made disclosures in reliance upon my prior consent. If I do not sign this consent, ADLS may decline to provide treatm en t to me.

I a uthorize ADLS to release informatio n to the following people:

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ Phone: _ _ _ _ _ _ _ _ Relationship:_ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ _ _ Phone:____________________ Re lationship:_ _ _ _ _ _ _ _ _ _ _

Name : _ _ _ _ _ _ _ _ _ _ _ _ _ _ Phone:____________________ Relationship:_ _ _ _ _ _ _ _ _ _ _

______ igna tuce of Patient or Legal Gua rdian

____
Prin t Name of Patient or Legal Guardian

____
Patient's Name

____
Date

Aesthetic Dermatology and La ser Surgery

Jonith Y. Breadon, M.D. & Associates

Missed Appointment and Cancellation Policy

At Aesthet ic Dermatology and Laser Sur g ery, our goal is to provide quality care in a timely manner. With this in mind, we have implemented a missed or cancelled appointment policy. This allows us to bett er utilize available appointments for our patients. Mi ssed appointments, lat e cancellations and late arrival s are disruptive to our schedule and other patients. Therefore, a new fee will be applied which will be outlined below.

Cancellation/Reschedule of an Appointment

To be respectful of the medical needs of other patients, please call ADLS prompt ly if you are unable to att end your sch eduled appointme nt. Appoi n tments are in high demand, and your early cancellation/reschedule will provide the opportunity to have access to care. An appointment MUST be cancelled 2-businessdays {or 48 hours) in advance of the appointment time and date to avoid a cancellation fee.

No-Show Policy

A "no-show" is someone who does not contact the office prior to the scheduled appointment to cancel or reschedule and appointment. A "no-show" is also som eone who arrives and leavesthe office prior to care being provided. This includes not having insurance cards, refusing to complete paperwork, or unwillingness to follow routine office policy. "No-Shows" inconvenience those individuals who need access to medica l care as well as the Physician. All "no-shows" will be subject to the cancellation fee schedule shown below.

Late Cancellations

Cancelled/rescheduled appointments within 2 business days (or 48 business hour s) of the scheduled appointment is considere d a "no-sho w" and the cancellation fee schedule below will be applied. We may waive a single cancellation fee 1 time per year, and only if the appointment is rescheduledwithin 30 business days of the original appointment date. The patient must attend the rescheduled appointment for the fee to be waived. If you "no show" to a rescheduled "no-sho w appointm ent, the previous "no-show" fee **PLUS** an d additi onal " no-show" fee will be applied.

Cancellation Fee Schedule

M edical visit - $50 | Cosmetic visit - $150

Surgic al Visit - $200

"* cosmetic, or surg ery patients may not besubject to a refund of their money i f the appointment is cancelled within 2 busin ess days of the scheduled appointment ""*

We er serve the right to dismiss patients from out pract ice after 3 missed/cancelled app ointments in a 1-2mon t h p eriod. New patients that miss/ cance l are also held to thi s policy.

By signing below, I have read and understand th e above policy.

Print patient/Guardian name

Date

1009 W Fulton Market Street Chicago, IL 60607 p: 312-733-2492 f: 312-733-2498

www.dr breadon.co m