RIVERSIDE MEDICAL ARTS

Received and completed by _____

PATIENT INFORMATION

Title	Sex	Date of Birth
☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II ☐ I	☐ Female ☐ Male	mm / dd / yyyy

First Name | Middle Initial | Last Name

Physical Address | City | State | Zip

Mailing Address | City | State | Zip

Cell Phone Number ( ) -

Other Phone Number ( ) -

Email Address

Confidential Communication Preference
☐ Email ☐ Letter ☐ Other _____ ☐ Patient Portal

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown

Preferred Language

Ethnicity
☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown

Race
☐ American Indian ☐ Asian ☐ Black /African American ☐ Native Hawaiian ☐ Other Pacifica Islander ☐ White ☐ Other

Employer Name

PARENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE INFORMATION

Title	Sex	Date of Birth
☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II ☐ I	☐ Female ☐ Male	mm / dd / yyyy

First Name | Middle Initial | Last Name

Mailing Address | City | State | Zip

Email Address

Cell Phone Number ( ) -

SPOUSE OR EMERGENCY CONTACT

First Name | Last Name

Relation to Patient

Cell Phone Number ( ) -

REFERRAL

How did you hear about our clinic?

Referred by

SIGNATURE

Signature of Patient or Legal Guardian

Date mm / dd / yyyy

Patient Account # _____

RIVERSIDE MEDICAL ARTS

PATIENT HEALTH INFORMATION

First Name	Middle Initial	Last Name	Date of Birth mm / dd / yyyy

ALLERGIES AND REACTIONS

Allergy	Describe Reaction	Allergy	Describe Reaction

PHARMACY

Preferred Pharmacy

MEDICATIONS

Current Medications:

HAVE YOU EVER HAD ANY OF THE FOLLOWING TREATMENTS?

☐ Botox	When was your last treatment?
☐ Filler	When was your last treatment?
☐ IPL (Foto Facial)	When was your last treatment?
☐ DiamondGlow	When was your last treatment?
☐ Chemical Peel	When was your last treatment?
☐ Micro Needling/ RF Micro Needling	When was your last treatment?
☐ Dermaplaning	When was your last treatment?
☐ Laser Hair Removal	When was your last treatment?
☐ Waxing	What area? When was your last treatment?
☐ DOT Laser (Fractional CO2)	When was your last treatment?
☐ Cosmetic Surgery	When?

DO YOU TAKE OR USE ANY OF THE FOLLOWING?

☐ Accutane How long have you been using this?	☐ Retinol or Retin A _____% How long have you been using this?	☐ Appetite Suppressant ☐ Stimulants/ Med for ADD or ADHD How long have you been using this?
☐ Hydrocortisone _____% How long have you been using this?	☐ Renova _____% How long have you been using this?	☐ Oral Antibiotics_____ How long have you been using this?

HISTORY

Do you wear sunscreen daily? ☐ Yes, Which brand? _____ ☐ No	Do you use a tanning bed? ☐ Yes, How often? _____ ☐ No
Have you ever had skin cancer? ☐ Yes, When and what kind? _____ ☐ No	Have you ever had a cold sore? ☐ Yes, When was your last outbreak? _____ ☐ No
Do you have problems with scarring (keloid)? ☐ Yes ☐ No	Do you have problems with bleeding? ☐ Yes ☐ No
Are you currently pregnant? ☐ Yes ☐ No	Are you currently breast-feeding? ☐ Yes ☐ No

WHAT ARE YOUR SKIN CONCERNS? PLEASE CHECK ALL THAT APPLY

☐ Fine lines and wrinkles	☐ Deep lines and wrinkles	☐ Tone/Texture
☐ Redness	☐ Brown Spots	☐ Facial Hair
☐ Sagging Skin	☐ Acne	☐ Other

ARE YOU INTERESTED IN MORE INFO ON ANY OF THESE SERVICES?

☐ Botox/Fillers	☐ IPL (Foto Facial) ☐ Chemical Peel	☐ DiamondGlow ☐ Dermaplaning
☐ DOT Laser/ Resurfacing	☐ Laser Hair Removal	☐ Micro Needling/RF Micro Needling and (PRP)

WHAT SKINCARE PRODUCTS ARE YOU CURRENTLY USING?

Patient Account # _____

RIVERSIDE MEDICAL ARTS

Patient First Name	Patient Last name
Parent / Guardian Name	Relation to Patient

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts Notice of Privacy Practices.

PATIENT RIGHTS AND RESPONSIBILITIES

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts patient rights and responsibilities.

DISCLOSURE OF OWNERSHIP INTEREST

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts disclosure of ownership interest.

LABORATORY

My signature below indicates I understand that all lab work ordered by my physician and sent to an outside lab will be billed separately by that lab to my insurance company. I understand that I am responsible to pay for all lab charges, whether or not I have insurance and whether or not it is a covered benefit of my insurance. I understand that the laboratory will bill me separately for these lab charges.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS / BILLING AGREEMENT

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill. Please provide complete insurance information to our office prior to your visit. If this information is not produced, payment for the services rendered will be due at the time of your visit. It is your responsibility to know the benefits provided by your insurance carrier. Please direct questions regarding your benefits to your insurance carrier or your human resources department. Riverside Medical Arts will make a reasonable attempt to inform you if your insurance is out of network. However, if your insurance is out of network you are responsible to pay for all services rendered. Payment in full will be due at the time of service if a particular service is not covered, we are unable to verify coverage, your coverage is pending or you are ineligible for coverage. Our office will file a claim with your primary insurance carrier. If a service requires additional information from the patient / guarantor, you are required to provide the necessary information to your insurance company or our office as soon as possible. If this information is not received by either the insurance company, or our office the payment for services rendered will then be the responsibility of the patient / guarantor. As a courtesy our office will file a claim with your secondary insurance company. If the services are unpaid by your secondary insurance carrier or require follow up, payment for services rendered are the responsibility of the patient / guarantor. In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. A denial from your insurance company does not release you from your financial obligation to us. Payments on accounts billed are expected within 30 days of the statement date. A $25.00 returned check fee will apply for every returned check that is received by our office. Delinquent accounts will be charged interest at 1.5% per month. The undersigned specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with the said collection action processing.

I hereby authorize the physician(s) of Riverside Medical Arts to release any information acquired in the course of my examination to my insurance company, another physician or hospital, adjuster or attorney. I authorize payment directly to Riverside Medical Arts for surgical and/or medical benefits, if any, otherwise payable to me for services as described. I understand that I am financially responsible for all charges whether or not paid by my insurance company. A photocopy of this assignment of benefits shall be considered as effective and valid as the original. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf. Any lab testing done in the office or outside laboratory will be billed separately by the laboratory. I consent to any medical treatment deemed medically necessary by the provider. I understand that these treatments will be discussed with me and all questions will be answered before it is rendered.

SIGNATURE

Signature of Patient or Legal Guardian	Date mm / dd / yyyy

Patient Account # _____