PATIENT REGISTRATION & PAYMENT AGREEMENT

Please give the receptionist your photo I.D. and current insurance card(s)

Reston Dermatology & Cosmetic Center
Syed Amiry, D.O.
1830 Town Center Drive, Suite 410
Reston, VA 20190
(703) 766-2220 / (571) 323-1486 (fax)

Patient Information:

Patient Name: _____ DOB: ____/____/_____ Age: _____

Patient SSN: _____-_____-_____ Sex: M_____F_____ Marital Status: M____S____D____W_____

Address: _____ City: _____

State: _____ Zip Code: _____ E-Mail Address: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell: (_____) _____

Employer: _____ Title: _____

Referring Doctor: _____ Phone: (_____) _____

How did you hear about us? _____

If an existing patient referred you, please write his/her name: _____

Pharmacy Information:

Pharmacy Name: _____ Phone: (_____) _____

Pharmacy Address: _____

Spouse Information:

Spouse Name: _____ DOB: ____/____/_____ Age: _____

Spouse SSN: _____-_____-_____ Employer: _____ Work Phone: (____) _____

Primary Insurance Information:

Insurance Co. Name: _____ Phone: (_____) _____

Address, City, State & Zip Code: _____

Policy ID: _____ Group: _____

Subscriber Name: _____ Subscriber DOB: ____/____/_____

Subscriber SSN: _____-_____-_____ Relationship to Patient: _____

Does your plan require a referral? _____ Copay Amount: $_____

Secondary Insurance Information:

Insurance Co. Name: _____ Phone: (_____) _____

Address, City, State & Zip Code: _____

Policy ID: _____ Group: _____

Subscriber Name: _____ Subscriber DOB: ____/____/_____

Subscriber SSN: _____-_____-_____ Relationship to Patient: _____

Does your plan require a referral? _____ Copay Amount: $_____

Patient/Guardian Signature: _____ Date: _____

Beginning January 1, 2019

To cancel or reschedule an appointment please contact our office at least 48 hours prior to your scheduled appointment. Please see our Appointment Cancellation/No Show Policy below.

By signing below, I acknowledge the following:

Cancelling, Rescheduling or No Show/Arriving Late to an Appointment

Important: A "no-show" is someone who misses an appointment without notice, or arrives more than 10 minutes late to their appointment. A "late cancellation/re-schedule" is someone who cancels or re-schedules without giving a 48 hour notice.

COSMETIC and AESTHETICIAN APPOINTMENTS:

- 1st NO SHOW/LATE CANCELLATION patient will be reminded of policy.
- 2nd NO SHOW/LATE CANCELLATION patient will be charged $125.00
- 3rd NO SHOW/LATE CANCELLATION patient will be charged $125.00 per occurrence and may be required to pay in advance for treatments. If the pre-paid appointment is missed, the patient may lose the amount pre-paid.

**The above fees are charged to the patient and are due prior to rescheduling

GENERAL DERMATOLOGY APPOINTMENTS:

We offer a 10 minute grace period to your scheduled appointment; however, our office reserves the right to assign your appointment time to another person, if you are more than 10 minutes late, and may result in a fee.

- 1st NO SHOW/LATE CANCELLATION patient will be reminded of policy.
- 2nd NO SHOW/LATE CANCELLATION patient will be charged $25.00
- 3rd NO SHOW/LATE CANCELLATION patient will be charged $75.00 per occurrence and may be dismissed from the practice.

**The above fees are charged to the patient, not the insurance company, and are due prior to rescheduling

- ***As a courtesy***, when time allows, we send email and text messages reminding you of your appointment. If you do not receive our messages, the above Policy will remain in effect.

Emergency situations will be handled on an individual basis.

I certify that I understand the above information

Patient name (print) _____

Patient Signature _____

Date _____

Insurance Information

By signing below, I acknowledge the following:

As the patient, it is my responsibility:

- To contact my insurance company to determine whether this office participates with my medical insurance coverage and to inform the office of any changes to my insurance.
- To obtain referrals from my primary care physician for each visit, if required by my insurance.
- to check my insurance plan prior to the office visit and prepare for any and all charges that my insurance company does not cover. This includes deductibles, copays, and other non-covered services. Payment is due at the time of service.
- For appointment fees without insurance, if applicable. Appointment fees without insurance are $200 for the initial visit (not including any treatment or lab work) and $100 for follow up visits (not including any treatment or lab work) due at the time of service.

Parents/guardians are responsible for payments on child accounts.
For your convenience, we accept most major credit cards. **We do not accept checks.**

By signing below, I authorize:

- Insurance payments to go directly to the physician.
- Release of necessary medical records to the insurance company to process payment.

HIPAA Acknowledgement

By signing below, I acknowledge that I have an opportunity to review, if desired, this practice's "Notice of Privacy Practices."

Please mark which phone numbers we can use to leave messages identifying this practice.
Home____ Cell ____ Work ____
Please mark which phone numbers we can use to leave laboratory/biopsy results or other care issues.
Home____ Cell ____ Work ____
To whom, if anyone, may we disclose laboratory/biopsy results or other care/financial issues:

Name _____ Relationship _____

I certify that I understand the above information and that the information I have given is correct to the best of my knowledge.

Patient name (print) _____ Patient Signature _____

Date _____

Patient Name _____

History and Intake Form

Past Medical History (Please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial Joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial Fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	**None**
Coronary Artery Disease	Hypothyroidism	

Other _____

Past Surgical History (Please circle all that apply)

Appendix Removed	Mechanical Valve Replacement	Prostate Removed: Prostate Cancer
Bladder Removed	Biological Valve Replacement	Prostate Biopsy
Mastectomy (Right, Left, Bilateral)	Heart Transplant	TURP
Lumpectomy (Right, Left, Bilateral)	Joint Replacement, Knee (Right, Left, Bilateral)	Skin Biopsy
Breast Biopsy (Right, Left, Bilateral)	Joint Replacement, Hip (Right, Left, Bilateral)	Basal Cell Cancer Surgery
Breast Reduction	Joint Replacement within the last 2 years	Squamous Cell Carcinoma Surgery
Breast Implants	Kidney Biopsy	Melanoma Surgery
Colectomy: Colon Cancer Resection	Kidney Removed (Right, Left)	Spleen Removed
Colectomy: Diverticulitis	Kidney Stone Removal	Testicles Removed (Right, Left, Bilateral)
Colectomy: IBD	Kidney Transplant	Hysterectomy: Fibroids
Gallbladder Removed	Ovaries Removed: Endometriosis	Hysterectomy: Uterine Cancer
Coronary Artery Bypass	Ovaries Removed: Cyst	**None**
PTCA	Ovaries Removed: Ovarian Cancer	

Other _____

Skin Disease History (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	**None**

Other _____

Do you wear sunscreen?	Yes	No	If yes, what SPF? _____
Do you tan in a tanning salon?	Yes	No	
Do you have a family history of Melanoma?	Yes	No	

If yes, which relative(s)? _____

Cautions (Please circle all that apply)

Have you had an adverse reaction to latex or epinephrine?	Yes	No	If yes, describe your reaction: _____
Have you ever had difficulty stopping bleeding?	Yes	No	
Do you require antibiotics prior to a surgical procedure?	Yes	No	
Have you had an artificial joint replacement?	Yes	No	If yes, when and what body location? _____
Do you have an artificial heart valve?	Yes	No	
Do you have a pacemaker?	Yes	No	
Do you have a defibrillator?	Yes	No	
Are you pregnant or currently trying to get pregnant?	Yes	No	
Are you currently breastfeeding?	Yes	No	

Medications (Please enter all current medications)

_____

_____

_____

Allergies (Please enter all allergies)

_____

_____

_____

Social History (Please circle all that apply)

Do you smoke?	Yes	No	Have you smoked in the past?	Yes	No	
Do you drink alcohol?	Yes	No	How many drinks per day?	<1	1-2	3+
Drug Use	Yes	No				

Other _____

What are your concerns?

- ☐ Lines and Wrinkles
- ☐ Scarring
- ☐ Excess Fat
- ☐ Varicose Veins / Spider Veins
- ☐ Unwanted Tattoos
- ☐ Saggy Eyelids
- ☐ Saggy Cheeks / Jowls
- ☐ Double Chin
- ☐ Sun Damaged Skin
- ☐ Torn Ear Lobe
- ☐ Brown Discoloration
- ☐ Turkey Neck
- ☐ Excess Sweating
- ☐ Unwanted Hair
- ☐ Brown Spots / Blemishes
- ☐ Facial Redness / Spider Blood Vessels

Would you like to learn about any of the following procedures?

- ☐ Botox
- ☐ Radiesse
- ☐ Laser Hair Removal
- ☐ Scar Treatment
- ☐ Sclerotherapy
- ☐ Liposculpture / Liposuction
- ☐ Lipoaugmentation
- ☐ Microdermabrasion
- ☐ Laser Tattoo Removal
- ☐ Micro Blepharoplasty
- ☐ Eyebrow Lift
- ☐ Chemical Facial Rejuvenation (Peels)
- ☐ Aesthetician Services
- ☐ CoolSculpt
- ☐ Silhouette InstaLift
- ☐ Ultherapy
- ☐ Skin Tightening

We also offer cosmetic products at the Reston Dermatology & Cosmetic Center. Please check the products you use or would like to learn more about:

	Use	Learn More
Luminous	☐	☐
SkinMedica	☐	☐
SkinCeuticals	☐	☐
Avène	☐	☐
Dr. Mercola	☐	☐