

Medical History

(Please Print Clearly)

Dermatology

The Center for Cosmetic Dermatology

[] Suzanne Bruce, M.D.

[] Leigh Ellen Eubanks, M.D.

[] Miriam L. Hanson, M.D.

Patient: _____

Date of Visit: _____

Referring Physician: _____ Physician's Address: _____

Telephone: _____

Primary Care Physician: _____ Address: _____

(if different from Referring Physician above)

Telephone: _____

Do you have any drug allergies? _____ If so, please list: _____

Have you ever had any reactions to local anesthetics? Yes [] No []

If yes, please explain: _____

List all prescription and non-prescription medications you are currently taking: _____

Please check appropriate box if you have a history of, or are currently under treatment for, the following conditions (if any are "yes", please explain on lines below):

- | | | |
|--|---------------------------------------|---|
| [] yes [] no Heart Problems | [] yes [] no Hepatitis | [] yes [] no Organ Transplant |
| [] yes [] no High Blood Pressure | [] yes [] no Diabetes | [] yes [] no Xray Therapy |
| [] yes [] no Pacemaker | [] yes [] no Kidney Problems | [] yes [] no Ultraviolet Light Therapy (PUVA/UVB) |
| [] yes [] no Stroke | [] yes [] no Arthritis | [] yes [] no Skin Cancer |
| [] yes [] no Blood Clots | [] yes [] no Epilepsy | [] yes [] no Cancer |
| [] yes [] no Bleeding Problems | [] yes [] no Glaucoma | [] yes [] no Keloids |
| [] yes [] no Lung/Breathing Problems | [] yes [] no Rheumatic Fever | [] yes [] no Currently Pregnant/Nursing |
| [] yes [] no HIV | [] yes [] no Artificial Joint/Valve | |
| [] yes [] no Psychiatric Condition | | |

Other: _____

[] yes [] no Previous Surgery? If yes, explain type of surgery and give dates (mo/yr) of each surgery: _____

[] yes [] no Do you have a family history of melanoma? If yes, who in the family had melanoma (relationship)? _____

[] yes [] no Alcohol Use? How much and how often? _____

[] yes [] no Tobacco Use? Types and amounts used per day? _____

Signature of Patient (responsible party and relationship if patient is a minor)

Date

Physician Signature

Date

The Center for Cosmetic Dermatology
1900 St. James Place, Suite 650
Houston, Texas 77056
Phone: 713.850.0240 * Fax: 713.850.0895
Suzanne Bruce, M.D. * Leigh Ellen Eubanks, M.D. * Miriam L. Hanson, M.D.

FINANCIAL POLICY

Thank you for choosing The Center for Cosmetic Dermatology. We are committed to the success of your cosmetic dermatology treatment and care. Please understand that payment of your bill is part of this treatment and care. **Please initial each of the following numbered items:**

1. _____ Patients will be charged for cosmetic consultations. Payment is due at the time services are rendered and does not apply towards the cost of procedures.
2. _____ All procedures performed at The Center for Cosmetic Dermatology are considered cosmetic and therefore are not covered by insurance. Payment is expected at the time of service. For your convenience, we accept cash, check, MasterCard, Visa, American Express and Discover.
3. _____ If you are unable to keep your cosmetic appointment, kindly notify our office a minimum of 24 hours in advance. We will require a \$100.00 deposit for all cosmetic procedures excluding consultations. The deposit will be applied if you do not show for your appointment or give less than 24 hours notice.
4. _____ We offer a discount on FotoFacials if you purchase a package of five treatments upfront. In order to receive the discount, you must purchase the package by your second treatment.
5. _____ Please understand that if you purchase skin-care products and/or supplies from our office, these items are non-refundable. In the event the products or supplies are defective, we will gladly replace the items at no additional cost to you.
6. _____ In the event we receive a returned check due to insufficient funds, a fee of \$25.00 will be charged to your account and payment is due upon receipt of notification.

Again, thank you for choosing our Center. If you have any questions, please don't hesitate to ask us. We are here to assist you any way possible.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient/Guardian Signature

Date

Cosmetic Interest Questionnaire

Patient Name: _____ Date: _____

Please check any issues and procedures of interest to you and give this form to the doctor or medical assistant during your visit.

- | | |
|---|---|
| <input type="checkbox"/> Skin-care advice and products | <input type="checkbox"/> Redness/ Rosacea |
| <input type="checkbox"/> Sunscreen advice/ Sun damage | <input type="checkbox"/> Brown spots/ Melasma |
| <input type="checkbox"/> Botox | <input type="checkbox"/> Sagging skin |
| <input type="checkbox"/> Dermal fillers | <input type="checkbox"/> Acne & other scars |
| <input type="checkbox"/> FotoFacial (IPL)/ FotoFirm | <input type="checkbox"/> Restoring volume to the face |
| <input type="checkbox"/> Fraxel or Thermage | <input type="checkbox"/> Stretch marks |
| <input type="checkbox"/> Lip enhancement | <input type="checkbox"/> Laser hair removal |
| <input type="checkbox"/> Forehead wrinkles/ Frown lines | <input type="checkbox"/> Removing facial/leg veins |
| <input type="checkbox"/> Wrinkles around the eyes | <input type="checkbox"/> Cellulite |
| <input type="checkbox"/> Laser treatments | <input type="checkbox"/> Spa services |

We also have two monthly electronic newsletters called the *Skin-e-letter* and the *Spa-e-letter*. With these newsletters you will be the first to hear about the monthly specials, promotions and upcoming events.

Please check your preference(s):

_____ Sign me up for the *Skin-e-letter*, featuring the latest advances and specials in cosmetic dermatology.

_____ Sign me up for the *Spa-e-letter*, featuring the latest products and services, including specials, in the SPA at SBA.

Your email: _____

We encourage you to get the skinny each month from Suzanne Bruce and Associates so you can stay in the know and take advantage of our monthly procedure, treatment and product specials. You can elect at any time to discontinue this service easily through the e-letters each month.

Thank you.

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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

****You have the right to refuse to sign this Acknowledgement****

I, _____, have been given the opportunity to read a copy of this office's Notice of Privacy Practices. I also understand, that I have the right to request a copy of the Notice of Privacy Practices for my records.

Patient or Guardian if minor

Date

Please print name

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

Other: _____

Practice Representative

Date

SUZANNE BRUCE AND ASSOCIATES, P.A.

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED
AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION**

**PLEASE REVIEW CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner or provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure performed by your authorization while it was in effect. Unless you give us written authorization, we cannot use or discuss your health information for any reason except those described in this Notice.

To Your Family and Friends: With your authorization we can disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail message, postcards, or letters. Please initial if you consent: _____

Marketing: We may use your name and address in order to mail you a copy of our quarterly newsletter called "The Skinny" which contains information about upcoming seminars, new and improved treatment options, specials, as well as general medical and cosmetic dermatology information for our patients. Please initial if you consent: _____

Laboratory/Pathology/Culture Results: All negative results are mailed to the patient's home address in a two-fold post card. If you wish to have your results mailed to another address or in sealed envelope, please provide us with your request in writing. If you consent to the procedure outlined above, please initial: _____

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your health information, with limited exceptions. You must make a request in writing to obtain access to your healthcare information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request his accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency situations. You may obtain a form to request restricted disclosure by using the contact information listed at the end of this Notice.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to an alternative location. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written format.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice please contact Kelly Goodman, Director of Operations, 713.796.9199. All complaints must be submitted in writing.