LAWLOR DERMATOLOGY

Tara Lawlor, DO | Waylon Steele, NP-C
MEDICAL | SURGICAL | COSMETIC DERMATOLOGY

Medical History

Do you now have, or have ever had the following skin conditions?
Check all that apply.

- ❑ Acne
- ❑ Actinic keratoses
- ❑ Asthma
- ❑ Basal cell carcinoma
- ❑ Blistering sunburns
- ❑ Dry skin
- ❑ Eczema
- ❑ Flaking or itchy scalp
- ❑ Hay fever / allergies
- ❑ Melanoma
- ❑ Poison ivy
- ❑ Precancerous moles
- ❑ Psoriasis
- ❑ Squamous cell carcinoma

Other: _____

- ❑ Atypical moles
- ❑ Cold sores
- ❑ Nickel allergy

If yes to any 'skin cancer' history above, please list the type, when you had it and how it was treated:

Past medical history: check all that apply.

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fib/irregular heartbeat
- ❑ Bleeding Disorder
- ❑ Blood Clots
- ❑ Bone marrow transplant
- ❑ BPH(benign prostatic hyperplasia)
- ❑ Breast cancer
- ❑ Colon cancer
- ❑ COPD(emphysema)
- ❑ Coronary artery disease
- ❑ Depression
- ❑ Diabetes
- ❑ End stage renal disease
- ❑ GERD (acid reflux)
- ❑ GI Disease
- ❑ Hearing Loss
- ❑ Hepatitis/Liver Disease
- ❑ High Blood Pressure
- ❑ HIV
- ❑ High Cholesterol
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke

Other:
_____
_____

History of Cancer(s): _____
_____

Family History of Melanoma?:
_____
_____

PAST SURGICAL HISTORY:

_____
_____
_____

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FB: LawlorDermatology | IG: @Steele.Aesthetics

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First visit details and medical history continued

Patient name: _____ DOB: _____
Reason for visit: _____

What is your occupation? _____

Pharmacy location and phone number: _____
_____

Any prior tanning bed use?_____ Blistering sunburns? __ YES __ NO

Do you wear sunscreen when outdoors? _____ if so, what SPF? _____

Are you allergic to any medications?___YES ___NO
If yes, list:_____

Have you ever had a reaction to dental or local anesthesia?: __ YES __ NO
If yes, describe reaction: _____

Do you take antibiotics before you go to the dentist? __ YES __ NO
If yes,why? _____

Do you have a pacemaker or implanted defibrillator? __ YES __ NO

If female, are you pregnant? __ YES __ NO Nursing? __ YES __ NO

Do you smoke? __ YES __ NO If Yes, How Much?_____
Do you drink alcohol? __ YES __ NO If Yes, How Much?_____

List all medications that you regularly take: (including prescriptions, over the counter meds, vitamins and herbal supplements)
_____
_____
_____

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Patient Contact Information

Appointment date and time:_____

Name:	Age:
Address:	Date of Birth:
❏ Male ❏ Female Marital Status ❏ Married ❏ Single ❏ Widowed	SSN:
Primary Language: ❏ English ❏ Spanish ❏ Other	HOME PHONE: MOBILE: WORK:
Race: ❏ American indian or alaska native ❏ Asian ❏ Black or african american ❏ Native hawaiian or other pacific islander ❏ White ❏ Other	Primary Care Doctor & Address: Ethnicity: Not Hispanic or Latino | Hispanic or Latino
EMAIL:	Preferred Contact: HOME | MOBILE | WORK | EMAIL

Insurance policy holder information / responsible party complete:

Name: Relationship to Patient:	Employer:
Address:	Contact Number:
DOB:	Male | Female

Emergency contact

Name:	Relationship:
Contact number:	

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Print Name: _____ DOB: _____

As a patient of our practice, from time to time we may need to communicate with you. To preserve your privacy, please indicate your preferred method for us to communicate medical information to you and others involved in your care.

Examples of medical information include test results, appointment reminders, and other information of a clinical nature.

Without specific permission, we will not release your medical information.

Please identify those individuals to whom we may release your medical information.

Name:	**Relationship:**	**Phone Number:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ Do not leave any medical information on machine or voicemail.

☐ I give permission to Lawlor Dermatology to notify me of test results, appointment reminders and other information regarding my health information as follows:

_____ Message on answering machine (Phone #_____)

_____ Message on work voicemail (Phone #_____)

_____ Message/text on cell phone (Phone #_____)

_____ Email Address _____

I assume responsibility to inform the practice of changes in my telephone numbers and my preferences.

Signature: _____ Date: _____

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Patient HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to conduct:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day health care operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that your practice maintains the most up to date version of its Notice of Privacy Practices. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signature: _____

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Patient Financial Responsibility Agreement

Thank you for choosing Lawlor Dermatology for your cosmetic needs. It is our pleasure to offer you the latest cutting edge services and medical grade products to meet your skin care needs. Please take a moment to familiarize yourself with our policies.

Payment

This account is self-pay and payment is required in full at the time of each service. Various insurance policies are accepted for medical visits. We accept the following forms of payment: Cash, Checks (with valid ID; no out of state), Visa, MasterCard, Discover. Financing options are available through CareCredit and Cherry. There is a returned check charge of $30.

Gift Cards and Packages

Gift cards are available and may be redeemed for specific cosmetic services and packages. Packages offer our clients significant savings. Services purchased as a package are ***not transferable***. If you are unable to use your full package, a credit may be issued at the discretion of the Provider. Refunds will not be provided. Credits are ***not transferable***. Packages must be redeemed within 1 year of purchase.

Promotions

Special promotions may not be combined with any other discounts.

Cancellation Policy

Lawlor Dermatology reserves the right to charge a $25 fee for the following:

- Dermatology appointments canceled 24 hours or less of scheduled appointment
- Dermatology no show appointments

Lawlor Dermatology reserves the right to charge a $150 fee for the following:

- Cosmetic appointments canceled 24 hours or less of scheduled appointment
- Cosmetic no show appointments

Outstanding fees must be paid in full prior to rescheduling a missed appointment.

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Arriving late will deprive you of valuable treatment time. We will make every effort to perform your entire treatment in the remaining scheduled time, but reserve the right to reschedule your appointment if you arrive more than 10 minutes late and charge the fee listed above.
I clearly understand and agree that all services rendered to me may be charged directly to me, and that I am personally responsible for full payment. I understand that even if I suspend or terminate treatment, any fees for professional services rendered to me or to my dependent up to the point of termination will be immediately due and payable.

I acknowledge that I am responsible for any outstanding fees for services provided to me by Lawlor Dermatology.

Any other arrangements that may involve payment plan or payment deferral must be made in writing with the office manager or business manager of the Practice. Verbal agreements are not acceptable.

I acknowledge that Lawlor Dermatology reserves the right to charge 50% of the desired service if I cancel the scheduled appointment 24 hours or less on the day prior to my appointment. I acknowledge that Lawlor Dermatology reserves the right to charge 100% of the desired service if I do not attend or cancel the scheduled appointment on the day of the scheduled appointment. I further acknowledge that Lawlor Dermatology reserves the right to reschedule my appointment if I am more than 15 minutes late to the scheduled appointment.

Printed Patient Name **Date** **Signature of Patient**

Practice Representative Name **Date** **Signature of Practice Representative**

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Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: DOB:

Address:

Phone: SSN (last 4 digits):

I authorize the custodian of records of:_____ or other person/entity (specifically describe) _____to disclose/release the following information.

(Check all that apply):

- ❏ All Records
- ❏ Billing Records
- ❏ Laboratory/Pathology Records
- ❏ X-Ray/Radiology Records
- ❏ Abstract/Summary
- ❏ Pharmacy/Prescription Records
- ❏ Other (describe specifically)_____.
  - ❏ *Note: if these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s):_____ .

Please send the records listed above to:

Waylon Steele, NP- C
2901 St. Lawrence Ave. Suite 201
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Phone: 610-301-0306 Fax: 610-628-9011

Signature of Patient (or personal rep.): Date:

Printed Name of Patient Representative:

Representative's Authority to sign for Patient:

(i.e. parent, guardian, power of attorney for healthcare)

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