Laser Center of Maryland
COSMETIC SURGERY & LASER SOLUTIONS

Patient Information Form

Patient Name: _____ Preferred Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Carrier: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Gender: _____ SSN: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____ Work Phone: _____

Who is your primary care physician? _____

How did you hear about our clinic?

☐ Patient Referral: _____ ☐ Dr. Referral: _____
☐ Friend: _____
☐ Google
☐ Other: _____

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance

Name: _____ Policy #: _____ Group ID: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance

Name: _____ Policy #: _____ Group ID: _____

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Assignment and Release

I,_____ , have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured / Guardian Date

Section I: Surgery and Anesthesia History

1. Have you ever had surgery? ☐ No ☐ Yes, please describe:

_____

_____

2. Do you have a blood relative who had anesthesia complications of any kind? ☐ No ☐ Yes, please describe:

_____

_____

Section II: Specific Medical History

1. Are you pregnant? ☐ No ☐ Yes Height: _____ Weight: _____

Have you or do you still have:	No	Yes	Description
2. Asthma	☐	☐	
3. Emphysema	☐	☐	
4. High Blood Pressure	☐	☐	
5. Heart Trouble	☐	☐	
6. Hepatitis or Liver Trouble	☐	☐	
7. Kidney Trouble	☐	☐	
8. Diabetes	☐	☐	
9. Epilepsy or Seizures	☐	☐	
10. Stroke	☐	☐	
11. Problem Scarring	☐	☐	
12. Have you been advised to or had psychiatric care?	☐	☐	

13. Others Not Listed: _____

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Section III: Social History

1. Do you smoke? ☐ No ☐ Yes, how much? _____
2. Do you drink? ☐ No ☐ Yes, how much? _____
3. Do you have children? ☐ No ☐ Yes, how many? _____

Section IV: Family History

Have any blood relatives had any of the following?	No	Yes	Description
1. Cancer	☐	☐	
2. Bleeding Tendency	☐	☐	
3. Leukemia	☐	☐	
4. Heart Disease	☐	☐	
5. High Blood Pressure	☐	☐	
6. Repeated Infections	☐	☐	
7. Chronic Lung Disease	☐	☐	
8. Tuberculosis	☐	☐	
9. Asthma	☐	☐	
10. Severe Allergies	☐	☐	
11. Kidney Disease	☐	☐	
12. Arthritis	☐	☐	
13. Mental Illness	☐	☐	
14. Convulsions or Fits	☐	☐	
15. Migraine Headaches	☐	☐	
16. Diabetes	☐	☐	
17. Gout	☐	☐	
18. Thyroid Trouble	☐	☐	
19. Obesity	☐	☐	

Section V: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

_____

_____

Section VI: Allergies and Sensitivities

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Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

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Consent to Communicate

Patient Name:_____

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message – if so, list cell carrier:			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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FOR PHYSICIAN USE ONLY

Physical Exam:

VS:

General:

HEENT:

CV:

Lungs:

Abdomen:

Skin:

Extremities:

Assessment:

Plan:

Patient was advised that Advanced Directives are not accepted

Physician Signature:_____ Date:_____

R.N. Signature: _____ Date:_____

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HIPAA Information and Consent Form

Patient Name: _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I,_____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes if office policy. I understand that this consent shall remain in force from this time forward.

Signature: _____ Date: _____

_____ _____

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No-Show Policy

Laser Center of Maryland is dedicated to providing the best possible service to our patients. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or does not cancel within 24 hours of his or her appointment there will be a charge to the patient of $50.

We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control. In this event, we ask that you call our office and cancel your appointment within 24 hours of the scheduled visit. This courtesy allows my office staff to schedule another patient who is also in need of a consultation with one of our providers.

Scheduled appointments and delays can happen however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Patient Name: _____

Patient Signature: _____**Date:**_____

LASER CENTER OF MARYLAND
484A RITCHIE HIGHWAY, SEVERNA PARK, MD 21146
410-544-4600

FINANCIAL BILLING AND CONSENT

The Laser Surgery Center is and outpatient ambulatory surgical center that specializes in dermatological laser procedures. Our ambulatory surgical center is a cost efficient, comfortable and personal alternative to an outpatient department in a hospital. As a courtesy to you, we complete an insurance claim for both the physician and facility charges and we provide the lab with your insurance information.

You may receive charges from two or three separate entities:

1. From the Laser Center of Maryland providers performing the procedure including: Dr. Ross Van Antwerp and/or his associates Dr. Jared Mallalieu, Mercy Brown, R.N and Amanda Hughes, R.N.
2. From the ambulatory surgery center.
3. From the pathologist/laboratory, if biopsies were taken.

Outlined below is an explanation of the various coverage groups and your financial responsibilities.

MEDICARE COVERAGE
Medicare allows for certain procedures performed at the ambulatory surgical center and will pay 80% of their allowable amount. If you have a supplemental policy, the remaining 20% will generally be paid. If there is no supplemental policy, the balance is your responsibility.

COMMERCIAL INSURANCE
Any balances will be reflected in a statement issued to you each month. You are responsible for any charges after 90 days regardless of pending insurance claims. We require payment at the time of service, unless otherwise specified.

ALL OTHER INSURANCES AND SELF PAY
We ask for payment in full the day of your service. A courtesy claim will be submitted to your insurance plan requesting them to reimburse you, unless you specify not to submit. We accept cash, checks, MasterCard, Visa, Discover, American Express, and Care Credit. Treatment packages are non-refundable for cosmetic treatments such as tattoo removal, hair removal, and skin rejuvenations.

Laser Center of Maryland
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I. CONSENT FOR TREATMENT

By signing my name I hereby certify that I understand and acknowledge the following:

1. I understand that the services are provided by Dr. Van Antwerp and/or his associates: Dr. Jared Mallalieu, Mercy Brown R.N and Amanda Hughes R.N. and that I will be billed for services rendered to me. I may also be billed by the Laser Surgery Center (herein after referred to as the "Center") for services provided by the facility.
2. I believe that I, or the patient to be treated, require medical treatment and hereby consent to such treatment, including anesthesia and laboratory diagnostic procedure, pertinent physical examination or other treatments may be considered necessary or advisable by my admitting physician or other Center personnel, including transfer to the nearest hospital if emergency treatment is necessary.
3. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been given to me by anyone as to the results that may be obtained from such treatment.

II. FINANCIAL AGREEMENT

In the event my insurance will pay all or part of the Center's and/or physician's charges, the Center and/or physician which render service to me are authorized to submit a claim for payment to my insurance carrier, but are not obligated to do so unless under contract with the insurer or bound by a regulation of a state or federal agency to process such claim.
In consideration of services rendered by the Center, Dr. Van Antwerp or any other providers, the undersigned hereby acknowledges personal, individual obligation, and guarantees prompt payment of such bills of the Center or the Laser Center of Maryland. Should any account be referred to an attorney for collection, the undersigned agrees to pay all reasonable attorney fees and collection expense. All delinquent accounts will be charged at the rate permitted by law. All returned checks will be subject to a $35 charge.

III. ASSIGNMENT OF INSURANCE BENEFIT

In the event I am entitled to benefits of any type whatsoever arising out of any policy of insurance covering me or any person who is or my become liable to me for such benefits, I hereby assign such benefits to the Center, Dr. Van Antwerp and/or his associates Dr. Jared Mallalieu, Mercy Brown R.N and Amanda Hughes R.N. who render services to me. Such insurance includes Medicare and Medicare supplemental insurances.
I understand and agree to be financially responsible to the Center and Dr. Ross Van Antwerp or other practitioners who render services and certify the information given with regard to insurance coverage is correct.

IV. RELEASE OF INFORMATION

I hereby expressly authorize the Center, the Laser Center of Maryland and Dr. Van Antwerp or his associates to release all or part of my medical records as needed or requested for payment purposes. The Center, the Laser Center of Maryland, its agents, servants, employees and physicians who render services to me are hereby released from any and all liability that may rise from the release of such information.

V. CERTIFICATE

I certify that I have read, understand and fully accept all terms specified above and that I have received the Laser Surgery Center's Patient Rights and ownership interest statements prior to date.

_____ _____

Signature Date

_____ _____ _____

Patient or Responsible Party Relationship Date

Laser Surgery Center, Inc
484 A Ritchie Highway, Severna Park, Maryland 21146
410-544-4600

Dear Patient,

Welcome to the Laser Surgery Center, Inc. we are pleased that you have chosen us to provide your health care services. In advance of your procedure, we are required to provide the following information:

Please be sure to bring your current insurance card, It is important that we have accurate insurance information for billing purposes. We participate with Medicare, however, we will complete a courtesy insurance claim for all other commercial insurance companies for members who have out of network benefits. We do not participate with HMO insurance companies. If I am a member of an HMO, I have been informed that Laser Center of Maryland is not participating with that HMO and if the Laser Center of Maryland provides services to me, I will be billed at the Laser Center of Maryland's usual rate and I, instead of my HMO, will be responsible for full payment of the at bill.

I understand that if, instead of receiving treatment from the Laser Center, I had elected to obtain treatment from a health care provider participating in my HMO and the HMO determined that the services was covered under my benefit plan, I would be entitled to have this service reimbursed as set forth in that plan.

Therefore, this means that:

1) I will be solely responsible for the Laser Center of Maryland's charges not covered by my insurance company
2) The Laser Center of Maryland will not seek payment from my HMO; and
3) The Laser Center of Maryland will not accept any payment from the HMO; and
4) As a member of an HMO, my obligation to HMO premiums will not be affected.

Laser Center of Maryland
COSMETIC SURGERY & LASER SOLUTIONS

PATIENT'S RIGHTS AND RESPONSIBILITIES

The services of the ambulatory surgery center shall be available to all individuals regardless of race, color, creed, sex, religion or national origin. All patients and their families shall be treated with respect, consideration and dignity.

All patients are encouraged to actively participate in their medical and surgical treatment plan. Patients shall be provided with all relevant information concerning their diagnosis, treatment and prognosis. When necessary or appropriate this information will be available and discussed with an appropriate patient designatee or legally authorized patient representative.

Representatives from the ambulatory surgery center will ensure the following information has been made available to each patient, both verbally and in writing, in a language and manner that the patient or the patient's representative understands:

1. Laser Surgery Center, Inc. provides surgical and diagnostic services. Patients shall be advised should the facility fail to maintain malpractice insurance.

2. The provisions regarding the normal hours of operation of the ambulatory surgery facility and specific directions to address after hours emergency concerns or issues which may arise. The patient, or the patient's representative, shall receive both written and oral discharge instructions providing guidance and appropriate telephone numbers to accomplish after hours contact

3. The patient shall receive clear and concise information regarding the procedures planned, the anticipated outcome or results, and the consequences of refusing treatment or not complying with the established treatment plan. There shall be a written, signed and witnessed surgical consent obtained prior to each surgical or diagnostic procedure performed in the facility.

4. The ambulatory surgery center shall not provide treatment to unemancipated minors not accompanied by an adult. The minor's parent, legal guardian or properly designated and pre-authorized representative must be present at the facility prior to an unemancipated minor receiving treatment in the facility. A pre-authorized patient representative must be designated in writing by the minor's parent or legal guardian prior to the date of surgery.

5. The patient shall be advised if the proposed treatment is experimental research. The patient shall be provided full and complete explanation regarding the procedure, the prognosis for success and alternatives. The patient shall have the right to refuse experimental research procedures, as well as any course of treatment with which they do not agree or approve. Patients may change their primary or specialty physician.

6. Each patient shall receive information regarding the fees associated with the use of the facility prior to the date of their procedure. The patient shall be advised of the ambulatory surgery center's policy regarding the processing of insurance forms, the payment of patient co-pays and deductibles and the policy concerning balance billing for services rendered. Patients shall be provided with appropriate privacy throughout the delivery of healthcare services.

7. All information provided to the patient concerning the ambulatory surgery center shall accurately reflect the facilities competence, capabilities, licensure, certification, and accreditation.

8. I have been advised that Ross Van Antwerp, D.O. has a financial interest or ownership of Laser Surgery Center, Inc.

9. Patients, or the patient's representative, will be advised in advance of the date of the procedure with information concerning the facility policies on advanced directives, including a description of applicable State health and safety laws, and, if requested, a copy of the official State advance directive forms. Patients may have advanced directives regarding their healthcare. Surgical center staff will inquire as to whether a patient has advanced directives and discuss the impact of such Advanced Directives on the patient's healthcare services to be provided by the surgery center. In the event of an emergent medical event occurring during your surgical procedure, you will be stabilized and 911 will be called to transport you to the closest hospital. **The surgery center does not recognize Advanced Directives.**

10. The surgery center has a grievance policy which provides a mechanism for the filing of grievances or complaints with the facility management. All alleged grievances or complaints will be addressed by the Medical Director within forty-eight hours. Any grievance or complaint relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, will be documented. The individual filing the alleged grievance or compliant will receive a written response within one week. Substantiated allegations will be reported to the State authority or the local authority, or both. All grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished will be immediately investigated and documented. The surgery center will document how the grievance was addressed, as well as, provide the patient with written notice of its decision. The decision will contain the name of the surgery center contact person, the steps taken to investigate the grievance, the results of the grievance process and the date the grievance process was completed.

    Grievances or complaints should be directed to Ross Van Antwerp, D.O. in writing or by telephone at 410-544-4600.

    Grievances or complaints regarding the surgery center may also be directed to the Maryland State Department of Health and Mental Hygiene, Office of Health Care Quality, Program Manager, Ambulatory Care Services, Bland Bryant Building, 55 Wade Avenue, Baltimore, Maryland 21228 or at 800-492-6005 or 410-402-8040 or by completing a written Compliant Report Form available from the ambulatory surgery center management.

    Additionally, grievances or complaints may be filed on the Web site for the Office of the Medicare Beneficiary Ombudsman at www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html.

11. The patient has the right to exercise his or her rights without being subjected to discrimination or reprisal; to voice grievances regarding treatment or care that is (or fails to be) furnished; to be fully informed about a treatment or procedure and the expected outcome before it is performed.

12. If a patient is adjudged incompetent under applicable State health and safety laws by a

court of proper jurisdiction, the rights of the patient are exercised by the person appointed under State law to act on the patient's behalf.

If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law.

13. The patient has the right to personal privacy, receiving care in a safe manner, and being free from all forms of abuse or harassment.

14. The surgery center will comply with the Department's rules for the privacy and security of individually identifiable health information, as specified at 45 CFR, parts 160 and 164.

15. Information regarding provider credentialing will be maintained by the surgery center and shall be available to patient's upon request.

PATIENT RESPONSIBILITIES

Arrive on time, prepared as directed, for your appointment. If an appointment needs to be changed or canceled, provide the surgery center as much notice as possible.

The patient shall provide accurate and up to date information concerning their health history, medications and insurance. Any changes to this information must be immediately conveyed to the surgery center staff.

If the patient is a minor, the parent or guardian is to remain in the ambulatory surgery center while the patient is undergoing treatment. The parent or guardian shall provide care and guidance to the minor patient concerning post-op and follow-up care.

The patient shall adhere to their physicians' directions regarding their health care treatment plan.

The patient is encouraged to ask their physician or other health care provider questions regarding their proposed course of treatment should they not clearly understand what is being recommended.

Patients are encouraged to obtain a second opinion, from another qualified physician or health care provider, should they be unsure of the proposed course of treatment.

Patients are expected to pay co-pays, deductibles and the balance of their medical bill according to the pre-arranged schedule of payment. If payment cannot be made, the administrator must be contacted prior to the due date of the payment.

Ask questions, whenever you are unsure of what is being proposed.

LASER SURGERY CENTER, INC.

Patient Name: _____

I hereby acknowledge I have been advised of the following surgery center practices and policies:

1. I have received a verbal explanation and have been offered a written copy of the Patient Bill of Rights. Initial ____

2. I have received information regarding the facility financial policies and I was offered a copy of the Facility Financial Policy. Initial ____

3. I have received information regarding the facility Privacy and Confidentiality Policy. I was offered a written copy. Initial _____

4. I have received information regarding the surgery center advance directives policy. I was advised I could receive a copy of the official State advance directives form. Additionally, I have been advised that should I have advance directives, I may bring them to the surgery center and they will be placed in my medical record. I was advised the surgery center does not recognize advanced directives.
   Initial _____

Do you have advance directives? Yes___ No___

Patient provided the surgery center with a copy of their Advance Directives. Yes___ No___

5. I have been advised that Ross Van Antwerp, D.O. has ownership or financial interest in the surgery center.
   Initial_____

Signature _____ Date _____

Witness _____ Date _____