Dr. Laura Ellis

Providing patients with the tools, products and programs to live happier, be healthier and look better.

30 Town Square Blvd, Suite 218 Asheville, NC 28803
P: 828-684-1212 F: 828-684-1103 www.lauraellismd.com

Employer: _____

Patient Information:

Name: _____

Address:_____

City:_____ State/Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Date of Birth: _____ Age: _____

Occupation: _____

Primary Care Doctor:_____

Primary Care Phone: _____

Referring Doctor: _____

Referring Doctor Phone: _____

How did you hear about us?: _____

_____

Assignment of Benefits- Financial Agreement:

I hereby give my authorization for insurance benefits to be made directly to Laura Ellis MD Skin Care & Vein Centre, PLLC. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney's fees. I hereby authorize this healthcare provider to release my insurance company all information necessary to procure the payment of benefits.

Patient signature: _____ Date: _____

We are a fragrance free office, please respect our patients and staff in this matter. Thank you!

Medical History:

30 Town Square Blvd, Suite 218
Asheville, NC 28803
Phone 828-684-1212 Fax 828-684-1103

Circle all that apply:

Yes No high blood pressure
Yes No low thyroid
Yes No liver disease or hepatitis
Yes No lung disease
Yes No heart disease
Yes No diabetes
Yes No HIV infection
Yes No kidney disease
Yes No acid reflux
Yes No bleeding tendency
Yes No acne
Yes No depression
Yes No epilepsy/seizures
Yes No anxiety
Yes No skin cancer
Yes No asthma
Yes No high cholesterol
Yes No arthritis
Yes No keloid scarring
Yes No tuberculosis
Yes No herpes, cold sores or shingles
Yes No blood clots in legs
Yes No blood clots in lungs
Yes No leg swelling
Yes No glaucoma
Yes No family history of glaucoma
Yes No rosacea
Yes No use Retin-A products?
Yes No use tanning booths?
Yes No smoke, How much?_____
Yes No alcohol use (#?_____/week/month)
Yes No think you are pregnant?
Date of last period_____

Have you had any of the following tests performed:

Yes No Mammogram or Thermography Date: _____
Yes No Pap Smear Date: _____
Yes No Prostate Exam Date: _____
Yes No Colonoscopy Date: _____
Yes No Full skin exam by Dermatologist Date: _____
Yes No General dental cleaning Date: _____

Any other illnesses?

_____

_____

List all medications that you take (including Supplements and Vitamins):

Name and dose/frequency:

_____

_____

_____

_____

_____

_____

_____

_____

_____

List all allergies to medications:

_____

_____

_____

_____

Yes No Are you allergic to iodine?

Yes No Are you allergic to latex?

Past surgical history:

_____

_____

_____

_____

_____

Patient signature: _____

Date: _____

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Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of the Notice of Privacy Policies by the staff of Laura Ellis MD Skin Care & Vein Centre, PLLC, detailing how my information may be used and disclosed as permitted under the federal and state laws. I understand the contents of the notice and I request the following restrictions concerning the use of my personal medical information:

_____

_____

_____

_____

Further, I permit a copy of the authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment benefits apply.

Signed:_____ Date:_____

If not signed by patient, please indicate relationship to patient:

Relationship:_____ Witness:_____

If the patient refuses to sign, indicate your attempt to obtain a signature below:

_____ Patient refused to sign this acknowledgement

Date:_____

Time:_____

Employee:_____

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Communication Authorization

Dr Laura Ellis and medAge Customized Medicine & Aesthetics would like to communicate with you in the ways you prefer. **By signing below, you allow us to disclose your protected health information (PHI) as described on this form.** PHI includes all information regarding your treatment and care. We may need to contact you for a number of reasons including to provide information about your treatment or payment for your care. We may disclose your PHI in other ways if it is permitted by law and we determine such disclosure to be necessary under the circumstances.

Patient Name: _____

Street Address: _____City,State,Zip_____

Patient Date of Birth: _____ Today's Date: _____

I hereby request the following regarding the use and sharing of my PHI:

1. Telephone messages: We may leave messages on answering machines or with individuals answering the phone at the numbers written in this section, including referral information, prescription refill reminders, appointment reminders, test results, and other information the Practice determines to be appropriate to leave on voice mail or with the person answering the phone. Please write the number(s) you would like us to use on the line below or if you do not want us to leave messages, write "none" or leave this blank:

_____

List all phone numbers, including are code, where the practice may leave messages, if applicable.

2. Sharing PHI with family and friends: In addition to any individuals who may be handling messages left as allowed in section 1 above, or individuals we may contact in emergencies or as otherwise allowed by law, you allow us to discuss PHI with the following family members, friends, or other individuals you list below and on any additional sheet attached to this form:

_____	_____
Print Name	Print Name
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip	City, State, Zip
_____	_____
Phone number, including area code	Phone number, including area code

3. Email Communication: Sending your PHI by email carries risk. Most standard email does not provide a secure means of communication. There is a risk that PHI contained in an unencrypted email may be disclosed to, or accessed by, unauthorized individuals. Emails can be lost or misdelivered. Use of more secure communications, such as by phone, is always an alternative that is available to you. If you do not receive a response to an email sent to the Practice, please call or write instead. If you allow us to share your PHI by email at the address you have written on this form, please neatly print the address here:

Email Address: _____

4. Wireless Calls and Texting: You consent to receive treatment, scheduling and account-related calls from the Practice at the following numbers: Landline_____, mobile: _____. Texts may be generated and sent automatically using auto- dialing technology. Calls may be pre-recorded and also auto-dialed. You are not required to provide consent to receive calls or messages in order to receive healthcare services. Messages and data rates apply.

5. Sensitive Conditions: We may discuss sensitive conditions directly with you that involve Highly Confidential Information (see definition below), either in personal, by mail, or over the phone. If you allow us to disclose PHI regarding certain sensitive conditions including, but not limited to Highly Confidential Information by email, telephone messages, or wireless calls and texting as described on this form, please initial here: _____.

Do not use emails or texting to communicate with us regarding urgent or time-sensitive matters. In a medical emergency, call 911.

It is your responsibility to make sure that only authorized people are allowed to access your email, phone messages, and mobile devices. If individuals other than you receive your PHI sent in the ways allowed on this form, they may share it with others and state and federal privacy laws will not protect it.

By signing below, you agree that this document is effective for one calendar year, or until you provide a new form, tell us in writing that you revoke it, or 5 years after you are no longer a patient of the Practice, whichever is sooner. You do not have to sign this form. If you do not sign, it will not affect the way we treat you. We will still communicate with you in person, by telephone, by mail, and as otherwise allowed by law.

_____ _____

Patient Name Printed Date

_____

Patient / Legal Representative Signature

_____

Legal Representative Printed Name and Description of Relationship (if applicable)