Patient Demographics

Patient Name: ________________________________ DOB: ____________SSN: ______________

Gender: ___Male ___Female Email: ____

Street Address: ___________________________________City: ___________________ State: ______

Zip: ___________ Home Phone: ______________________ Cell Phone: _________________________

Pharmacy Name: ___________________________ Pharmacy Location: _________________________

Primary Care Physician: ____________________________________ Phone: ______________________

Primary Ins: ___________________________ Policy #: ___________________Group #: ___________

Policy Holder's Name: __________________________ DOB: ___________Relationship: ____________

Secondary Ins: _________________________ Policy#: ____________________ Group: ____________

Emergency Contact and/or legal guardian if under 18

Name: _________________________ Phone: _______________ Relationship: ___________________

Consent for treatment: I authorize ReNu Medical & Spa and its personnel to provide ongoing medical care, treatment and procedures (skin biopsies, regular surgical procedures, etc.) as ordered by the physicians and/or other health care providers. Some tissue and cultures are sent to outside laboratories, if your insurance carrier requires a specific facility; please let our staff know at the time service is rendered. I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed.

Consent for release of information: I authorize ReNu Medical & Spa to release to my insurance carrier(s) including medicare, medicaid and any other reimbursing agency information about my identity, treatment, diagnosis, prognosis, and/or services rendered (including drug and alcohol abuse treatment, mental health treatment, diagnosis and/or treatment of HIV, AIDS, AIDS related illness or sexually transmitted diseases) as permitted by the state and federal law which may be required or requested, thus releasing ReNu Medical & Spa from any liability for furnishing such information. I understand information may be released through electronic or paper media.

Prescription refill policy: ReNu Medical & Spa has adopted a policy requiring all patients to be seen within one year in order to receive prescription refills

Notice of Health Information Practices: I acknowledge that the Notice of Privacy Practices is on file and I may access it at will.

Print name and relationship to patient: ____

Signature of patient or guarantor: ___________________________________ **Date:** ______________

Patient Name: ____ **Date:** ____________________

Have you had skin cancer? __Yes __ No What type: _________________________ When: _______________

Medical Conditions: (please circle all that apply)

Anxiety disorder	Arthritis	Asthma	Atrial fibrillation
Benign prostatic hyperplasia	Cerebrovascular accident	COPD	Coronary arteriosclerosis
Depressive disorder	Diabetes mellitus	Elevated blood pressure	End-stage renal disease
Epilepsy	Gastroesophageal reflux disease	H/O: hypertension	Hearing loss
Human Immunodeficiency Virus	Hypercholesterolemia	Hyperthyroidism	Hypothyroidism
Inflammatory disease of liver	Leukemia	Malignant lymphoma	Malignant tumor of breast
Malignant tumor of colon	Malignant tumor of lung	Malignant tumor of prostate	
Radiation therapy treatment management	Transplantation of bone marrow	None	

Other ____

Past Surgeries: (please circle all that apply)

Abdominoperineal resection	Bilat replacement of knee joints	Biopsy of breast	Biopsy of prostate
Coronary artery bypass graft	Entire transplanted kidney	Excision of BCC	Excision of melanoma
Excision of SCC	Colostomy	Tubal ligation	Appendectomy
Bilateral mastectomy	Cholecystectomy (Gallbladder)	Colectomy	Liver excision
Cystectomy	Transurethral prostatectomy	Hysterectomy	Kidney biopsy
Low anterior resection of rectum	Lumpectomy of breast	Mastectomy	Mech heart valve replacement
Oophorectomy	Pancreatectomy	Prostatectomy	Prosthetic arthroplasty of bilat hip
Splenectomy	Surgical biopsy of skin	Total nephrectomy	Total orchidectomy

Total replacement of hip joint, side: ________ Total replacement of knee joint, side: _________

Transplantation of heart Transplantation of liver Percutaneous extraction of kidney stone procedure

Other: ____

Skin Conditions: (please circle all that apply)

None	Acne	Actinic keratosis	Asteatosis cutis	Basal cell carcinoma
Contact dermatitis due to poison ivy		Dry skin dermatitis	Dysplastic nevus of skin	Eczema
H/O: asthma	H/O: hay fever	Malignant melanoma	Pruritus of scalp	Psoriasis
Squamous cell carcinoma		Sunburn of second degree		Other: ______________________

Do you wear Sunscreen? ___ Yes ___ No If yes, what SPF? __________

Hx of tanning bed use? ___Yes ___ No

Do you have a family history of Melanoma? __ Yes __ No

If yes, which relative(s)? ____

Medications: (please enter current medications along with dose and how often you take)

____

____

____

____

Allergies: (please list all allergies)

____

____

____

Social History: (please circle all that apply)

Cigarette Smoking:
Currently smokes
Has smoked in the past
Never smoked
Former smoker

Alcohol Use:
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Alerts: (please circle all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners (this includes Aspirin)
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to surgical procedures
Rapid heartbeat with Epinephrine
Are you pregnant or trying to get pregnant?

Family History: (only list first degree relatives)

____

____

____

____

Permission to Disclose Information

I authorize ReNu Medical & Spa to disclose the following protected health information:

____ Appointment times and dates
____ Test results
____ Lab results
____ Talk to the Provider or Nurse

Spouse Name: ______________________________________ Phone: _________________________________

Family:

Name: ____ Phone: _________________________________

Name: ____ Phone: _________________________________

Name: ____ Phone: _________________________________

Name: ____ Phone: _________________________________

Friends:

Name: ____ Phone: _________________________________

Name: ____ Phone: _________________________________

Print Name: ____

Signature of Patient or Guardian: ____ Date: ____________

2425 Bradshaw Way, Pittsburg, KS 66762 Ph: 620-308-6123 Fax: 620-308-6264
Renumedicalandspa@gmail.com

Financial Policy

The physician and staff at ReNu Medical & Spa, LLC are committed to provide each of our patients with quality health care in a way that is financially responsible for both our patients and our practice. We agree to accept assignment from many insurance companies and when possible, review medical/health care options based on cost. In return we expect our patients to:

If you have insurance that we accept, we expect you to:

- Pay your copay, deductible amount or coinsurance amount at the time of service
- Be responsible for understanding the details of your insurance coverage, requirements for prior authorization for procedures, referrals, annual deductibles and copay/coinsurance amounts
- Bring a current copy of your insurance card to every visit and notify us of changes in insurance coverage. If we do not have current insurance billing information, we will expect full payment of care at time of service

If you do NOT have current insurance, we expect you to:

- Pay in full at the time of service

Methods of Payment: We accept cash, personal checks, debit/credit cards – Visa, Mastercard, American Express and Discover as forms of payment. Debit/Credit card transactions will be assessed a $2.50 fee. If your check is returned for any reason, a fee of $30.00 will be added to your account. Our bank will continue to seek payment on your check. If your check is returned to us, we will notify you. We reserve the right to refuse future payment by check.

Past Due Accounts: We consider patient accounts (not including payment we are expecting from insurance filing) to be past due if they are not paid at the time the services are provided. If the account is not paid, we will turn your account over to a private debt collector.

We work with most medical insurers, carriers vary, but we will try to help you get the most out of your particular policy. As a courtesy to you, we will submit your claim forms for you and answer any questions we can. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. We do require that you pay the portion that your insurance policy does not cover each visit.

We appreciate the time you have taken to read and understand this policy. If you have any questions about any aspect of this policy, please speak with our office manager. We feel that it is important for you to understand our financial policy clearly and that you feel comfortable agreeing to uphold it.

Print Name: ____

Signature of Patient or Guardian: ____ **Date:** ____________

2425 Bradshaw Way, Pittsburg, KS 66762 Ph: 620-308-6123 Fax: 620-308-6264
Renumedicalandspa@gmail.com

CANCELLATION AND NO-SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24-hour notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24-hour notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24-hour notification may be subject to a **$50.00 Cancellation Fee**.

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered a **NO SHOW**. Patients who No-show two (2) or more times in a 12 month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to a **$50.00 fee for office appointment No Show Fee**.

The Cancellation and No-Show fee are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel with 24 hours. Fees in this instance may be waived but **Only with Management Approval**.

For **Spa services** we ask that all clients provide a credit card to put in a secure file for our cancellation and no-show policy. We ask that you cancel your appointment at least 24 hours in advance. If you do not cancel in advance, you will be charged **50% of your service price** for missing your appointment with your on-file credit card. You will be allowed to reschedule ONCE without any additional charge. If you reschedule a second time, you will be charged **100% of your booked service price**. Late policy: If you are 10 or more minutes late, we may ask you to reschedule your appointment so it will not affect our punctual clients. If we are unable to take you at the time you arrive, you will be charged for **50% of the service** you missed.

Our Practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no-show fees should be directed to the Billing Department at 620-308-6123.

Please sign that you have read, understand and agree to this Cancellation and No-Show Policy.

Print Name: ____ Date of Birth: ________________________

Signature of Patient or Guardian: ____ Date: ____________

Patient HIPAA Awareness

With my permission, Dr. Jacqueline M. Youtsos and all employees of ReNu Medical & Spa, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Jacqueline M. Youtsos and all employees of ReNu Medical & Spa, LLC reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office.

With my permission, the office of Dr. Jacqueline M. Youtsos and all employees of ReNu Medical & Spa, LLC may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Jacqueline M. Youtsos and all employees of ReNu Medical & Spa, LLC may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards, clinical results and patient statements.

I have the right to request that Dr. Jacqueline M. Youtsos and all employees of ReNu Medical & Spa, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Jacqueline M. Youtsos and all employees of ReNu Medical & Spa, LLC to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Print Name: ____

Signature of Patient or Guardian: ____ **Date:** ____________