

# Cosmetic Dermatology Center

Nicole Hayre, MD  
8377B Greensboro Drive  
McLean, VA 22102  
(703) 827-8600

## Patient Information Form

Today's Date: \_\_\_\_\_

### Patient's Name

\_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Address \_\_\_\_\_  
Street & Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Any restrictions for contacting you?  No  Yes

Contact Restrictions: \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

How did you hear about Dr Hayre?: \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_  
Street & Suite # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Please be advised that most of the procedures performed by Dr Hayre are not covered by insurance plans as they are considered to be cosmetic. Therefore, Dr. Hayre does not participate with insurance plans. She will, upon request, provide a billing statement which you may submit to your insurance company. Your insurance company will then issue a check directly to you for the amount covered by them. Please remember that your insurance company may require a referral for your office visit, which you must obtain from your primary physician.

I have read the above, and agree to the terms set forth therein.

Signature of Patient/Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Name of Patient / Guardian (Printed) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

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## **Financial Agreement and Appointment and Cancellation Policy**

*(Please read thoroughly, initial and sign at the bottom.)*

Payment for all visits and services are due in full on the day they are rendered. We accept cash, Visa, Mastercard, American Express and Discover. **Personal checks are not accepted.**

If for whatever reason payment is: delayed; rejected; not received or is cancelled for any reason, Client understands and expressly agrees that he/she is personally liable for the outstanding payment to include additional costs associated with attorney's fees or collection agency fees required to ensure payment by the Client.

Further, Client understands and expressly waives any and all privacy concerns associated with the Health Insurance Portability and Accountability Act (HIPAA) and any other relevant state law as it pertains to the release of confidential information required for the purposes of obtaining payment for services rendered. It is understood that the release of personal information will be limited to only that which is required for the purposes of collecting payment.

### **24 Hour Cancellation Policy\***

- You will be billed a \$50 "No Show/Cancellation Fee" for each general dermatology or consultation appointment missed or cancelled within 24 hours of your scheduled appointment. In addition, if you are too late to allow for your scheduled appointment you will be billed a late fee.

**Initial:** \_\_\_\_\_

- You will be billed a \$150 "No Show/Cancellation Fee" for all procedure appointments missed or cancelled within 24 hours of your scheduled appointment time. (Botox, Fillers, Lasers, Excisions, Biopsies, etc.) In addition, if you are too late to allow for your scheduled appointment you will be billed a late fee.

**Initial:** \_\_\_\_\_

### **Holiday Appointment Policy\***

- Due to high demand for appointments during the holiday season, a deposit is required to reserve your appointment. Our holiday season runs from **October 15** through **January 1**. All appointments and consultations require a \$75 deposit, while all procedure appointments require a \$150 deposit.

**Initial:** \_\_\_\_\_

- All deposits will be applied toward your fees at the time of your visit. Deposits will be forfeited if we receive less than 24 hours notice of cancellation or in the event of a "No Show".

**Initial:** \_\_\_\_\_

*\*All no show/cancellation and holiday appointment fees are non-refundable\**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## Patient Medical History

Name \_\_\_\_\_ DOB \_\_\_\_\_

Are you currently under the care of a physician for a specific condition? Yes No

If Yes, List reason (s): \_\_\_\_\_

List all current medications: \_\_\_\_\_

List all Allergies: \_\_\_\_\_

Circle all that apply:

Blood Thinners  
Uncontrolled Diabetes  
Sinus Infections  
Facial/Oral Surgery  
Urticaria (hives)  
Hepatitis  
High Blood Pressure  
Lupus

Viral Lesions (Herpes Simplex)  
Vascular Lesions  
Pregnant/Nursing  
Auto Immune Disease  
Skin Cancer  
Hair Loss  
Low Blood Pressure

Psychiatric  
Psoriasis  
Eczema  
Acne  
Nail Problems  
Contact Dermatitis

Please explain any items circled above:

History of cosmetic procedures (Lasers, Microdermabrasion, Peels, Botox, Fillers, etc):

Please list your current skin regimen: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Consent for Photographic Documentations

I understand that photographic documentation is an integral part of Dr. Hayre's practice. I consent to photos being taken and understand that they will be kept with my medical records. I am aware that Dr. Hayre receives many requests to give educational speeches and to publish her findings in medical journals. I consent to my photos being used as educational material. I also understand that every effort will be made to conceal my identity.

**Please check one:**

I consent to photos being taken **only** for the purpose of my medical record.

I consent to photos being taken for the purpose of my medical record and possible medical publication. I also understand that every effort will be made to conceal my identity.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness's signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

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### **Notice of Privacy Practices**

This notice describes how information about you may be used and disclosed during your medical treatment and how you may gain access to this information. Please review it carefully.

Examples of uses and disclosures for treatment:

- If the doctor requires your medical records from another physician's office or if the doctor refers you to another physician's office and has records sent to them.
- If the doctor requests testing, labs and technicians may send your results electronically to our secure fax.
- The physician or staff may call you and leave a message for you to return our call.

Examples of uses and disclosures to operate the practice:

- The staff may call or email you to remind you of or follow-up after an appointment.
- The staff may mail or email you notices from the practice.
- The staff may submit a claim or authorization form to your insurance that contains your name, address, social security number, diagnosis, and procedures performed in our office.

Please note that the practice may only disclose your information with your consent with the exception of when the law requires us to disclose information to government authorities. Examples of such cases include infectious disease.

You have the following rights regarding your protected health information and the practice must act within 60 days:

- You may request to inspect or receive a copy of your protected health information.
- You may request that your information be amended.
- You may request a copy of this notice.

The law requires the practice to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices.

The law requires the practice to abide by the terms of this notice and to provide individuals with notice revisions.

You may complain to the practice or to the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

Once signing this consent, you fully understand our obligation to uphold your privacy as well as our obligation to potentially use and disclose your medical information in concern of your treatment or as means of operating our practice.

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Patient or Authorized Signature

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Date