JUVA®
Skin & Laser Center
Body Contouring Center
MediSpa

No Data Changes
Staff Initial _____ Date _____
Staff Initial _____ Date _____
Staff Initial _____ Date _____
Staff Initial _____ Date _____
Staff Initial _____ Date _____

Date: _____
Patient's Name: Mrs. Miss Ms Mr. Dr._____
Address: _____Apt#_____ City, State, Zip_____
Home Phone: ( )_____Business Phone: ( )_____Cell Phone_____
Social Security Number: _____-_____-_____ Date of Birth: _____ Age: _____
Occupation: _____Employer: _____
E-mail:_____
Allergies: _____
Family Doctor:_____ Telephone_____
Can we call you at work? ____No ___Yes Please provide an authorized person/phone number who can receive your medical information in the case of an emergency _____
Phone Number:_____

Please answer all questions: How were you referred to us:
Referring Physician _____Friend_____
Insurance ____☐____Google Search ____☐____JUVA Website ____☐____Facebook____☐__
TV Segment ____☐____ Magazine____☐____ ZocDoc____☐___Other_____
Do you want to be on JUVA's email list and receive information on JUVA events & specials Yes☐_No_☐_

Please answer all insurance questions completely:
Primary Insurance: _____ **Please circle: HMO PPO POS Other**
Address of insurance:_____
Identification #_____ Group Number:_____
Insured's Name:_____ Insured's Social Security number:_____
Insured's date of birth:_____ Relation ship to patient:_____
Secondary Insurance: _____ Please circle: HMO PPO POS Other
Address of secondary insurance:_____
Identification #: _____Group Number: _____
Insured's Name:_____ Insured's Social Security Number:_____
Insured's date of birth: _____ Relation ship to patient: _____

PATIENT FINANCIAL RESPONSIBILITY AND MUTUAL AGREEMENT

I hereby assign my insurance benefits to be paid directly to the physician in this office. I hereby authorize the release of medical information related to the services received in this office.
If I do not have a valid referral for any visit as required by my insurance plan, I agree that I will be responsible for providing a valid referral within 48 hours of my visit. By signing below, I accept financial responsibility for all charges incurred at any visit if the appropriate referral is not received in the time specified or for non-covered services performed. I agree that a full body check constitutes my annual exam as per insurance guidelines.
I agree all cosmetic or elective services will be paid at the time service is rendered and I understand that any consultation fee and/or cosmetic or elective procedure charges cannot be submit to insurance.
I agree to pay all fees owed for services hereunder within thirty (30) days of date of service and agree to pay a late fee equal to 1.33% per month on any past due amounts. Should it become necessary to use an outside collection agency and/or to initiate litigation to collect payment from me, I agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs and expenses, including reasonably attorney's fees, we incur in such collection efforts.

PATIENT/GUARDIAN_____DATE_____

JUVA has a policy to ensure the privacy of your medical information that is in concordance with the federal Health Insurance Portability and Accountability Act (HIPAA). You have the right as a patient of JUVA to receive a written or verbal explanation of the program to maintain confidentiality. I acknowledge that JUVA has given me a copy of its office privacy notice.
I am aware of JUVA's policies and their patient bill of rights.

I request that payment of authorized benefits from Medicare and/or my health insurance carrier(s) be made either to me or on my behalf to Bruce E. Katz, MD, Juliya Fisher, MD, Marianne Woody, NP , April Cannon, NP, Johanna Petrycki, PA, Denisse Serrano, PA, for services furnished to me by my provider. I authorize any holder of medical information about me to release medical records, lab reports, radiology reports, and/or photographs to the Centers for Medicare & Medicaid Services, my health insurance carrier(s), and/or its agents any information needed to support eligibility for coverage for medical services. I understand that if I do not cancel any of my appointments at least 24 hours before, I may be charged a cancellation fee.

Bruce E. Katz, M.D., P.C., JUVA Skin & Laser Center & East 56th Street Medical PLLC (collectively labeled "*Physician*") agree to provide treatment to: "Patient" named above. The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

I consent to receiving text and email communications from Bruce E. Katz, M.D., P.C., JUVA Skin & Laser Center & East 56th Street Medical PLLC. I understand that text/email communications are regarding promotional offerings or appointment reminders only. No private health information will be transmitted via text/email without my express written consent. I understand I am able to opt out of receiving these type of communications at any time.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

JUVA supports the right of each patient to develop an advance directive; however, such advance directive (variously also known as patient's living will, patient proxy for health care, DNR, DNI) I acknowledge that any advance directive I may have will be suspended and not be honored during the time I am in the JUVA office.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

PATIENT/GUARDIAN_____DATE_____

JUVA®
Skin & Laser Center
Body Contouring Center
MediSpa

Medical History

Name_____ Age_____ Date_____

Birth Place: _____ ☐Single ☐Divorced ☐Married ☐Widow(er)

Education: _____ Years High School _____ Years College _____ Years Post-Graduate

JUVA recommends using our partnered In-Network Pharmacy, Apothecary. Apothecary is located in lower Manhattan and offers free delivery to all NY patients. All prescriptions are electronically submitted.

Do you wish to use Apothecary as your pharmacy? ☐ Yes ☐ No. If no, please provide the below information.

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

What medications are you now taking? (Please list ALL prescription medications with their dose and frequency)

Medication Name	**Dose**	**Frequency**

Are you using any type of herbal medication? (If yes, describe)_____

What cosmetics, soaps, hair & skin products do you use regularly?_____

	CIRCLE ONE	IF YES, EXPLAIN
Do you have any allergies to medications?	No/Yes	Select One
Have you recently taken aspirin? Blood thinners?	No/Yes	Select One
Any sinus, hay fever or asthma in your family?	No/Yes	Select One
Do you have a personal or family history of skin cancer or melanoma?	No/Yes	Select One
Any trouble with healing? Keloid scars?	No/Yes	Select One
Have you ever had liver problems or hepatitis?	No/Yes	Select One
Do you have a pacemaker?	No/Yes	Select One
Do you have high blood pressure?	No/Yes	Select One
Do you have heart problems? Previous heart attack?	No/Yes	Select One
Do you have any lung or breathing problems?	No/Yes	Select One
Do you have any history of tuberculosis?	No/Yes	Select One
Do you have fainting spells? Any seizures?	No/Yes	Select One
Do you have diabetes? Low blood sugar?	No/Yes	Select One
Have you ever been hospitalized?	No/Yes	Select One
Have you ever had any cosmetic surgery?	No/Yes	Select One
Have you ever had major surgery?	No/Yes	Select One
Any serious illness or injuries in the past year?	No/Yes	Select One
Do you have a living will?	No/Yes	Select One

Woman – Menstrual History: Are you now having regular periods? If not, please explain._____

Do you take Birth Control Pills? ○ No/Yes ○ If yes, what brand?_____ How Long?_____

Are you planning to become pregnant? No/Yes

CONSENT FOR TREATMENT

I hereby give my consent for medical examination and treatment. I consent to routine dermatological procedures such as skin biopsy, treatment with liquid nitrogen, or the removal of minor skin lesions, etc. These procedures will be explained in detail before treatment.

Date_____ Signed_____

JUVA maintains your health care information in a confidential manner. Your information may be used for treatment, payment, and health care operations. For example, our physicians and nurses need access to your record to treat you, our billing office may use the information to obtain payment from your insurance, and our office managers may use the information for quality assurance purposes.

Your rights as a patient of JUVA under the Health Insurance Portability and Accountability Act (HIPAA) including the following:

1. You have the right to see and get copies of your record.
2. You have the right to request that specific person(s) not see your record.
3. You have the right to receive your medical information such as laboratory tests in a confidential fashion.
4. You have the right to request that your medical records be amended.
5. You have the right to request an accounting of everyone to whom the office reveals your medical information for purposes other than treatment, payment, or office operations.

If you want to learn the procedure to receive copies of your medical record, please contact a JUVA representative.

JUVA abides by federal, state, and local laws.

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. When we return calls and the answering machine picks up, we do not leave a message unless it is a reminder. Information also will not be left with an unauthorized person who may answer the phone.

I authorize the staff of JUVA Skin & Laser Center and East 56th Street Medical to leave medical information pertaining to my care by the following methods; this authorization will remain in effect until cancelled in writing by me:
Please use this/these method(s) to contact me:

- ☐ Home telephone _____
  - ☐ OK to leave message on voicemail?
- ☐ Home fax _____
- ☐ Work telephone _____
  - ☐ OK to leave message on voicemail?
- ☐ Secretary _____
- ☐ Cell Phone _____
- ☐ E-mail _____
- ☐ Other _____

If you would like to have information released to someone other than yourself, please complete the following: Please list the names of authorized individuals with whom JUVA Skin & Laser Center and East 56th Street Medical may leave messages with and/or speak to regarding medical information pertaining to your care (spouse, children, parent, significant other, secretary, etc.): This authorization will remain in effect until cancelled in writing.

Authorized Contact: _____

Relationship: _____ Phone: _____

Authorized Contact: _____

Relationship: _____ Phone: _____

Date: _____ Signature of Patient: _____

JUVA®
Skin & Laser Center
Body Contouring Center
MediSpa

Cancellation Policy for JUVA Skin & Laser Center

Dear Patient:

Please be advised that there is a 24-hour cancellation policy at JUVA Skin & Laser Center.

If you need to cancel your appointment, your cancellation must be received a minimum of 24 hours in advance of your scheduled appointment time. (Leaving a message on our voicemail the night before the appointment does not allow us enough time to schedule another patient in the cancelled slot) Failure to cancel a minimum of 24 hours in advance of your appointment will make you liable for a non-refundable cancellation fee of $100.00 for an office visit or a higher fee for a procedure. Failure to cancel a Mohs surgical procedure within the allowed time frame, a minimum of 24 hours in advance, you will be liable for the cancellation fee of $500.00. From time to time, as an executive and discretionary measure, fees may be waived on a case-by-case basis, particularly if you reschedule on the same day as the cancellation due to an unforeseen scheduling conflict.

All medically based cancellations will require a note from a physician or medical facility. Medically based cancellations will have this cancellation fee waived. We must also collect your credit card information in order to bill for deductibles, co-insurance charges, co-payments and cancellation fees. Please ask for our credit card policy sheet for further information.

Please sign this form acknowledging comprehension and agreement with the above policy and return to the office in-person, by fax to 212-421-9502, or scan and e-mail the signed document to mail@juvaskin.com.

Thank you in advance for your cooperation.

We will accept American Express, Mastercard, Visa and Discover. Please complete the following:

_____ _____

Name (Print) Date

_____

Signature

JUVA®
Skin & Laser Center
Body Contouring Center
MediSpa

Financial Responsibility Consent

To Our Patients:

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company as it makes checkout easier, faster, and more efficient.

JUVA Skin & Laser Center/East 56th Street Medical has implemented a similar policy. You will be asked to provide a credit card number at the time you check in and this information will be held securely until your insurance(s) have paid and/or notified JUVA of the amount that is your responsibility. At that time, any remaining balance owed by you will be charged to your credit card / debit card and a copy of the charge will be mailed to you.

This will be an advantage to you since you no longer will have to write out and mail checks to us. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Copays are due at the time of the visit. **A technology processing fee of 2% will be assessed on all credit card transactions. This fee will be waived if you pay with a debit card.**

If you have any questions about this payment agreement, do not hesitate to ask.

Sincerely yours,

JUVA Skin & Laser Center
East 56th Street Medical

I authorize JUVA Skin and Laser Center to charge outstanding balances on my account to the following credit card:
Visa Mastercard American Express Other: _____

Account # _____ Exp Date _____ CVV _____

Name on Card (please print) _____

Signature _____ Date _____

This consent has no expiration.

JUVA®
Skin & Laser Center
Body Contouring Center
MediSpa

Patient Name: _____ **Date:** _____

Reason for Today's Visit: _____

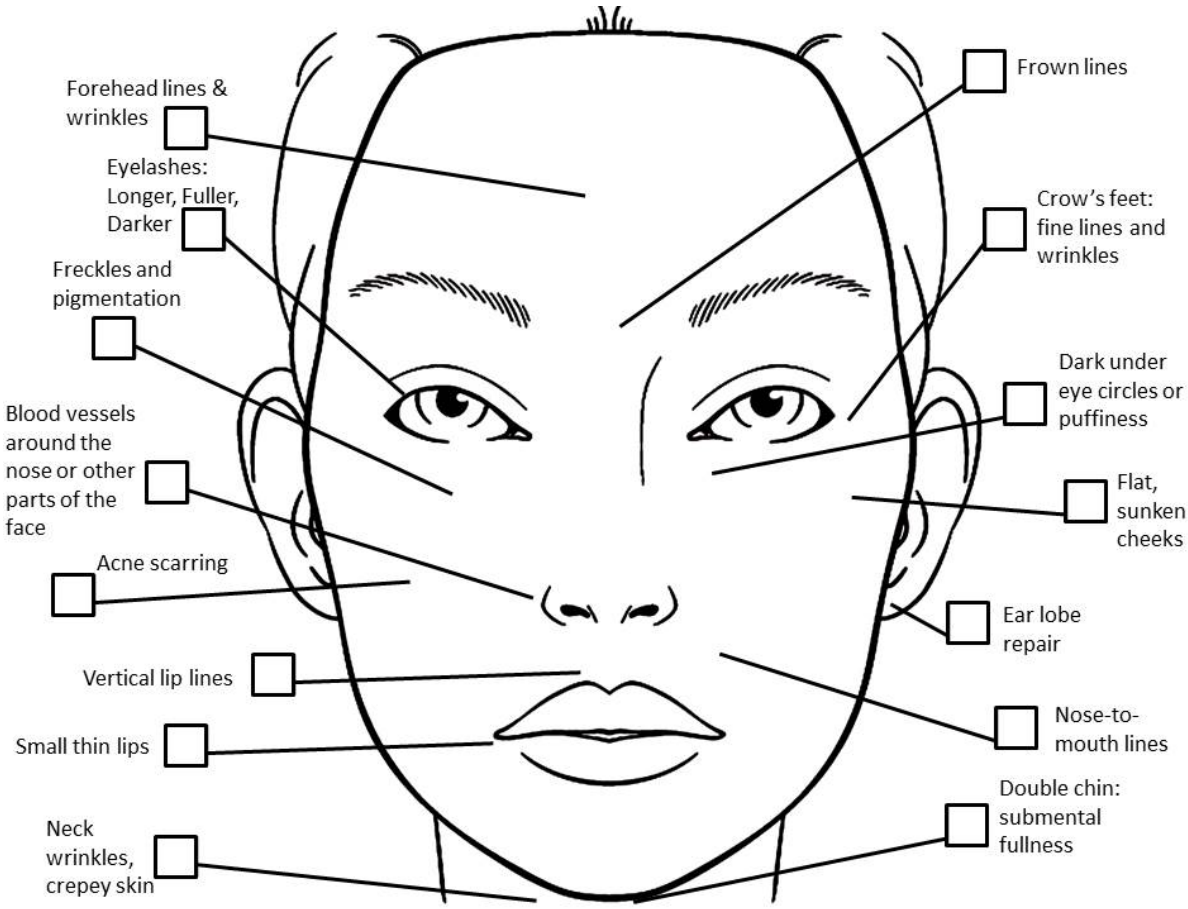
May we email you JUVA News and special offers? If yes, please provide your email address: _____

In addition to our medical dermatology, our physicians also specialize in numerous aesthetic and cosmetic procedures. To ensure we are meeting your needs, please check all that apply:

Body Procedures:

☐ Liposuction/SmartLipo
☐ Cellulite Treatment
☐ Feminine Rejuvenation
☐ Skin Tightening for Skin Laxity
☐ Non-invasive Fat Reduction
☐ Stretch Marks or Scarring
☐ Scalp Hair Thinning or Loss
☐ Laser Tattoo Removal
☐ Blue or Red Leg Veins
☐ Unwanted Hair
☐ Excessive Sweating

Face and Neck Procedures:



☐ Rough Skin Texture
☐ Brown Spots
☐ Uneven Skin Tone
☐ Red Spots
☐ Hyper-Pigmentation
☐ Laser Acne Therapy

What would you like to see at JUVA Skin & Laser Center? _____

Patient Signature: _____

Consent To Telehealth Visit

CONSENT TO TELEHEALTH VISIT

Bruce Katz MD, Juliya Fisher MD, Marianne Woody NP, PA-C Denisse Serrano, PA Johanna Petrycki

JUVA Skin & Laser Center Manhattan & Woodside

1. **Purpose.**
   The purpose of this form is to get your consent for a telehealth visit with dermatologists (expert skin doctors) at JUVA Skin & Laser Center. The purpose of this visit is to help in the care of your skin problem.

2. **How Telehealth Works.**
   In a telehealth visit, you will interact in real time with your dermatologist via a secure, online videoconferencing technology. Alternatively, the dermatologist may give you the option of submitting a photo and chief complaint via secured electronic messaging. Your dermatologist has the right to discontinue or not provide a consult via videoconference or secure electronic messaging should the videoconference connection or the forwarded image be of poor quality. You may be required to make an in-person appointment for further evaluation should this occur. The dermatologist will look at the patient's skin during a videoconference or review the photos you submitted.
   The dermatologist will then give you advice about your dermatologic condition and how to treat and take care of your condition. The information from the dermatologist will not be the same as a face-to-face visit because the dermatologist is not in the same room.

3. **Pros, Cons and Your Options.**
   With telehealth, a dermatologist will advise you based on viewing your condition during a videoconference or based on the photos that were submitted electronically. Sometimes a face-to-face follow-up visit with the dermatologist may still be needed. If you do not come into the office for an in-person visit, the dermatologist's advice will be solely based on the viewing your skin condition during a videoconference or on the information and images provided by you electronically. In the absence of an in-person physical evaluation, the dermatologist may not be aware of certain facts that may limit or affect his or her assessment or diagnosis of your condition and recommended treatment. It is possible that there will be errors or deficiencies in the transmission of the images of your skin condition during the videoconference or in the photos submitted electronically that may impede the dermatologist's ability to advise you about your condition. Also, very rarely, security measures can fail to protect your personal information, but the company that is providing the technology for your telehealth visit has extensive security measures in place to prevent such failures from happening.

4. **Presence of Others During Telehealth Visit**
   People other than your doctor may be a part of the patient's care and present during a telehealth visit. These people may be resident doctors (who have finished medical school and are now completing an "on-the-job" training in an office or hospital), medical students, or nurses. Anyone that is part of the telehealth team will be supervised by the dermatologist, and the final recommendations about your care will come from the dermatologist. Also, non-medical people may help to set up the telehealth equipment. You may ask for persons other than your dermatologist to leave the room if you are uncomfortable having them participate in your telehealth visit.

American Academy of Dermatology Association

JUVA®

Consent To Telehealth Visit

continued

5. **Medical Information and Records.**
All federal and state laws covering access to your medical records (and copies of medical records) also apply to telehealth. No one other than the health care team described above can view your photos or information unless you agree to give them access.

6. **Privacy.**
All information given at your telehealth visit will be maintained by the doctors, other health care providers, and health care facilities involved in your care and will be protected by federal and state privacy laws.

7. **Your Rights.**
You may opt out of the telehealth visit at any time. This will not change your right to future care or health benefits.

8. **Waiver/Release.**
By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your telehealth visit or in the electronic submission of your images to your dermatologist and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release your dermatologist and his or her institution or practice from any claims you may have about this advice or the telehealth visit generally. The consent provided in this document will expire in one year from the date you sign it, but your waiver and release shall apply indefinitely for any telehealth visits that occur during the one-year period after your signature date.

My doctor has talked with me about the telehealth visit. I have had the chance to ask questions and all of my questions have been answered. I have read this form, understand the risks and benefits of the telehealth visit, and agree to a telehealth visit under the terms explained above.

Signature of Patient _____ or Signature of Patient's Representative _____

Name of Interpreter / ID # _____ Relationship of Representative to Patient _____

Signature of Witness
(required if patient is unable to sign) _____ Date of Signing _____

Refusal: I do not want to be a part of a telehealth visit. _____
Signature

Click Here to Submit

For more information, contact the American Academy of Dermatology: aad.org

AAD American Academy of Dermatology Association