**James R. Wharton, M.D.**
13802 Lake Point Circle Louisville, Kentucky 40223
(502)245-4450 and (502)855-6200

Aesthetics Center of Louisville
James R. Wharton, MD

## GENERAL INFORMATION

Patient Name_____Preferred Name_____

Date of Birth _____/_____/_____Age_____Sex_____Height_____Weight_____

Address_____
Street City State Zip

Home Phone_____Cell Phone_____Work Phone _____

Social Security Number_____ Email_____

Emergency Contact: Name & Phone Number _____

**Responsible Person (if Applicable):**

Name_____Relationship to patient _____

Date of Birth _____/_____/_____Social Security Number_____

Home Phone_____Work Phone_____Cell Phone_____

**INSURANCE INFORMATION (Please present insurance cards and photo ID to the receptionist):**
Do you have health insurance? Yes ___ No ___

**AUTHORIZATION, RELEASE & AGREEMENT TO PAY FOR SERVICES RENDERED:**
I authorize James R. Wharton, M.D., PSC, to release my (my child's) medical information to the following individuals:

_____ Relationship:_____ Phone:_____

_____ Relationship:_____ Phone:_____

I authorize the providers to perform diagnostic procedures and treatment as may be necessary for proper medical care. I understand that as part of the medical procedures or tests relating to my medical care, I may be tested for human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease if a provider orders the test for diagnostic purposes. I authorize James R. Wharton, M.D., PSC, to release any medical information including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such care to third party payers and other health practitioners. I authorize and assign directly to James R. Wharton, M.D., PSC all medical benefits, if any, otherwise payable to me for services rendered. In the event I have a skin biopsy, I consent to having my biopsy sent to the pathologist my doctor determines is most appropriate for arriving at an accurate diagnosis of my condition. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event my account becomes delinquent and is turned over to collection agency, I will be responsible for up to a 40% surcharge in addition to my balance. I have received a copy of James R. Wharton, M.D., PSC's Notice of Privacy Practices.

_____ _____
**Patient or Responsible Party Signature** Date

For the purposes of providing reports in a more timely manner, I grant Louisville Dermatology and Aesthetics Center of Louisville permission to provide general correspondence, pathology, and lab results, via secure voicemail on the number listed above, unless otherwise specified. YES NO

_____ _____
**Patient or Responsible Party Signature** Date

**MEDICAL HISTORY**

NAME _____ DATE _____

**Past Medical History**: (Please circle all that apply): **NONE**

| | | | |
|---|---|---|---|
| Anxiety | Coronary Artery Disease | HIV/AIDS | Seizures |
| Arthritis | Depression | High Cholesterol | Stroke |
| Asthma | Diabetes | Hyperthyroidism | |
| Atrial fibrillation | End Stage Renal Disease | Hypothyroidism | |
| Bone Marrow Transplantation | GERD | Leukemia | |
| Breast Cancer | Hearing Loss | Lung Cancer | |
| Colon Cancer | Hepatitis | Prostate Cancer | |
| COPD | High Blood Pressure | Radiation Treatment | |

Other:_____

**Past Surgical History:** (Please circle all that apply): **NONE**

| | | |
|---|---|---|
| Appendix Removed | Mechanical Valve Replacement | Ovaries Removed: Endometriosis |
| Bladder Removed | Biological Valve Replacement | Ovaries Removed: Cyst |
| Mastectomy (Right, Left, Bilateral) | Heart Transplant | Ovaries Removed: Ovarian Cancer |
| Lumpectomy (Right, Left, Bilateral) | Joint Replacement, Knee (Right, Left, Bilateral) | Prostate Removed: Prostate Cancer |
| Breast Biopsy (Right, Left, Bilateral) | | Prostate Biopsy |
| Breast Reduction | Joint Replacement, Hip (Right, Left, Bilateral) | TURP (Prostate Removal) |
| Breast Implants | | Spleen Removed |
| Colectomy: Colon Cancer Resection | Joint Replacement within last 2 years | Testicles Removed(Right, Left, Bilateral) |
| Colectomy: Diverticulitis | Kidney Biopsy (Nephrectomy) | Hysterectomy: Fibroids |
| Colectomy: IBD | Kidney Removed (Right, Left) | Hysterectomy: Uterine Cancer |
| Gallbladder Removed | Kidney Stone Removal | |
| Coronary Artery Bypass | Kidney Transplant | |

Other:_____

**Skin Disease History**: (Please circle all that apply): **NONE**

| | | |
|---|---|---|
| Acne | Dry Skin | Poison Ivy |
| Actinic Keratoses | Eczema | Precancerous Moles |
| Asthma | Flaking or Itchy Scalp | Psoriasis |
| Basal Cell Skin Cancer | Hay Fever/Allergies | Squamous Cell Skin Cancer |
| Blistering Sunburns | Melanoma | |

Other:_____

Do you wear Sunscreen? Yes No

If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

**Current Medications: NONE**

Medication Name

1._____
2._____
3._____
4._____
5._____

**Drug Allergies: NONE**

Name of Drug Type of reaction (rash, hives, nausea, etc.)

1._____
2._____
3._____
4._____
5._____

**Social History** (please circle all that apply)

**Cigarette Smoking:**

Never Smoked
Has smoked in the past
Former Smoker
Currently Smokes

**Alcohol Use**

EtOH- None
EtOH- Less than 1 drink per day
EtOH- 1-2 Drinks per day
EtOH- 3 or more drinks per day

In the last year, on more than two occasions, have you consumed more than four (if female) or five (if male) drinks in a day? YES NO

Other:_____

Information entered, reviewed, and signed by provider in EHR

NAME _____ DATE _____

**General Family Medical History** (Only first degree relatives)

_____
_____
_____
_____

Primary Care Physician _____

How were you referred to our office? (Patient - Doctor)_____

Preferred Pharmacy Name: _____ Phone Number: _____
City, Zip Code: _____

I give my consent for Louisville Dermatology Clinic to import my pharmacy data from my Surescripts pharmacy **YES NO**

Preferred Language: _____ Race: _____ Ethnic Group: _____

What is the primary reason for your visit today?_____

**Review of Systems:** Are you currently experiencing any of the following? (Please check yes or no for the following)

| Symptom | Yes | No |
|---|---|---|
| Problems with bleeding | | |
| Problems with healing | | |
| Problems with scarring | | |
| Rash | | |
| Immunosuppression | | |
| Hay Fever | | |
| Chest Pain | | |
| Fever or Chills | | |
| Night Sweats | | |
| Unintentional Weight Loss | | |
| Thyroid Problems | | |
| Swollen Lymph Nodes | | |
| Sore throat | | |
| Blurry Vision | | |
| Abdominal Pain | | |
| Bloody Stool/Urine | | |
| Joint Aches | | |
| Muscle Weakness | | |
| Neck Stiffness | | |
| Headaches | | |
| Seizures | | |
| Cough | | |
| Shortness of Breath | | |
| Wheezing | | |
| Anxiety | | |
| Any Newly Pigmented Lesions | | |
| Depression | | |

**Alerts**: (Please circle all that apply):

**ALERTS REVIEWED AND NONE OF THE BELOW APPLY**

Allergy to Adhesive

Allergy to Lidocaine

Allergy to topical antibiotics

Artificial heart valve

Artificial joint replacement

Blood thinners

Defibrillator

MRSA

Pacemaker

Require antibiotics prior to a surgical procedure

Rapid heart beat with epinephrine

Are you pregnant or currently trying to get pregnant?

Other Symptoms:
_____

Have you received an influenza immunization in the past year? **YES NO** If yes, approximate date: _____
Have you ever received a pneumococcal vaccine? **YES NO** If yes, approximate date: _____
Do you have an advance care plan or surrogate decision maker? **YES NO**
If yes, my surrogate decision maker name & relationship to myself is: _____

Information entered, reviewed, and signed by provider in EHR

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## HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that:** Protected health information may be disclosed or used for treatment, payment, or health care operations. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The Practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

**Signature is required yearly. Please sign next available line.**

*This Consent was signed by:*

| | | | |
|---|---|---|---|
| _____ | ___/___/___ | _____ | ___/___/___ |
| **Signature** | Date | **Signature** | Date |
| _____ | ___/___/___ | _____ | ___/___/___ |
| **Signature** | Date | **Signature** | Date |
| _____ | ___/___/___ | _____ | ___/___/___ |
| **Signature** | Date | **Signature** | Date |

## AUTHORIZATION FOR MARKETING PURPOSES

HIPAA applies to "PHI" (Protected Health Information). This is information that identifies who the health-related information belongs to, i.e. names, email addresses, phone numbers, medical record numbers, photos, driver's license numbers, etc. If you have something that can identify a user together with health information of any kind (from an appointment, to a list of prescriptions, to test results, to a list of doctors) you have PHI that needs to be protected under HIPAA guidelines.
In an effort to update our privacy policies consistent with the new HIPAA guidelines for marketing purposes, we are requesting that all of our patients resubmit their request to receive emails from our practice regarding news, events, products, services and other marketing materials. Please read below the updated regulations for obtaining authorizations for marketing purposes.
I give permission to Aesthetics Center of Louisville and Louisville Dermatology Clinic to send emails for marketing purposes. I understand that my signature below permits this disclosure with no such expiration date. I understand by signing I am agreeing to allow Aesthetics Center of Louisville and Louisville Dermatology Clinic access to PHI including my name, email address and potentially mailing address for the purpose of marketing the practice and services offered. I understand that I have the right to revoke this authorization, at any time, by unsubscribing from the email list. This correspondence may lead to remuneration for the practice. We respect your privacy and do not sell your information to third parties. Although we do not anticipate additional disclosures, due to the nature of the email transmissions, by releasing your information, other disclosures may occur and that PHI may no longer be protected by the Privacy Rule. In terms of shared medical information, treatment may not be conditioned on receipt of the authorization, or under the circumstances where it can be conditioned such as for research purposes.
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____
**Signature** Date

_____
Email Address

I decline to receive communication via email correspondence for marketing purposes

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## Missed Appointment Policy

We're glad you have chosen us to provide your medical care, but if you miss your appointments, you inconvenience not only the staff but those individuals who need access to medical care in a timely manner. We want to remind you of our office policies regarding missed appointments.

**A missed appointment is when you fail to show up for an appointment without a phone call, or cancel without at least 24-hour notice.**

A doctor/patient relationship is built on mutual trust and respect. As such, we strive to be on time for your scheduled appointments, and ask that you give us the courtesy of a call when you are unable to keep your appointment. Below, our missed appointment policies are outlined.

Let's work together to provide you with the best possible care you deserve.

## Routine Office Visits

1. 1st Missed Appointment: You may reschedule your appointment.
   You may be charged a missed appointment fee of $25.
2. 2nd missed Appointment: You may reschedule your appointment.
   You may be charged a missed appointment fee of $25.
3. 3rd Missed Appointment: You will be charged a missed appointment fee of $25.
   This may result in a discharge from the practice.

## Office Procedure Appointments

1. 1st Missed Appointment: You may reschedule your appointment.
   You will be charged a missed appointment fee of $150.
2. 2nd missed Appointment: You may reschedule your appointment.
   You will be charged a missed appointment fee of $150.
3. 3rd Missed Appointment: This may result in a discharge from the practice.
   You will be charged a missed appointment fee of $150.

## Authorization / Assignment / Financial Responsibility

I understand that I am financially responsible for all charges. There are some procedures that require a deposit prior to the treatment date or are cosmetic procedures not billable through insurance. All procedures needing a deposit will be discussed with patient prior to scheduling. I understand that all sales and purchases are final.

My Signature below indicates that I have read and am in agreement with all above statements.

**Print Name:** _____

**Signature:** _____ **Date:** _____

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**Patient Name**:_____**DOB**:_____

***Photograph Release Form:*** I hereby acknowledge that I have been advised that photographs will be taken of me or parts of my body before and after my cosmetic procedure. The photographs will be taken by one of the members of the Aesthetics Center of Louisville / VIP Dermatology staff. I hereby give Aesthetics Center of Louisville / VIP Dermatology my consent to use the photographs under one of the following circumstances: **Please initial only ONE of the following:**

**1. ALL MEDIA**_____Photographs taken of me or parts of my body as well as details regarding medical services I have received at Aesthetics Center of Louisville / VIP Dermatology may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, our internet site and television, in order to inform the public about cosmetic treatments and methods. Further, I release and discharge Aesthetics Center of Louisville / VIP Dermatology, the facility use, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

**2. WEBSITE ONLY**_____Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Aesthetics Center of Louisville / VIP Dermatology may be used on our internet website in order to inform the public about cosmetic treatment and methods. Further I release and discharge Aesthetics Center of Louisville / VIP Dermatology, and employees of Aesthetics Center of Louisville / VIP Dermatology, any facility used, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment, in connection with any such use or publication. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party.

**3. PHOTO ALBUM ONLY**_____Photographs taken of me or parts of my body as well as details regarding medical services that I have received at Aesthetics Center of Louisville / VIP Dermatology may be used in the photograph album in order to inform other patients of Aesthetics Center of Louisville / VIP Dermatology, about cosmetic treatment and methods. Further I release and discharge Aesthetics Center of Louisville / VIP Dermatology, and employees of Aesthetics Center of Louisville / VIP Dermatology, any facility used, and all parties acting under their license and authority from any and all claims or actions that I have or may have relating to such use and publication and all rights, if any, that I may have in such photographs and details regarding medical services rendered me, including any claim for payment in connection with any such use or publication in the photograph album. I give my consent as a voluntary contribution in the interest of public education, and my consent is subject to only the condition that I am not identified by name at any time during any use of these materials by any party.

**4. MEDICAL CARE ONLY**_____Photographs taken of me or parts of my body can be used solely for the purpose of my medical care with Aesthetics Center of Louisville / VIP Dermatology. The photographs and all details regarding medical services rendered to me will be kept confidential within my personal medical history file at Aesthetics Center of Louisville / VIP Dermatology

**Date**_____ **Witness**_____

**Patient or Guardian Signature**_____