RADIANT
DERMATOLOGY & AESTHETICS

Liet N. Le, MD, FAAD
22659 HWY 59 North, Suite 140
Kingwood, TX 77339-4406
Ph: 281-973-4159 Fax: 281-973-2359

Today's Date _____
Patient's Name (Mr. / Mrs. / Ms.)_____
Parents (if minor)_____
Mailing Address_____
City /State/ Zip_____
Primary Phone_____ Work/Cell_____ Email_____
DOB_____ Sex_____ DL#_____ SS#_____-_____-_____
Marital Status_____ Religion_____ Race_____
Ethnicity (please circle): Hispanic or Latino Non-Hispanic or Latino Other Unknown Declined
What is your preferred language?_____

Primary Care Physician _____

How did you find our office? _____Name if referred by a friend or family_____

Emergency Contact Information: (Please provide a contact NOT living with you)

Name _____ Relationship _____ Phone_____

Responsible Party

Who is responsible for the account? (Mr. /Mrs. /Ms.) _____
Address/City/State/ Zip _____
Relationship to patient _____ SS#_____-_____-_____ DOB _____
Employer _____
Occupation_____ Primary Phone_____
Work/Cell _____ Other _____

Primary Insurance
Policy Holder:_____
Ins. Co._____
Policy # _____
Group # _____
Policy Holder's DOB _____
Relationship to Pt _____

Secondary Insurance
Policy Holder:_____
Ins.Co. _____
Policy #_____
Group # _____
PolicyHolder's DOB _____
RelationshiptoPt _____

Financial Policy

Any out-of-pocket expense for the patient such as co-pays, deductibles, or co-insurances, must be paid at the time of services including services that are not covered under the patient's benefit plan.

Authorization and Release (please sign below)
I authorize the release of any medical information necessary to process this bill to my insurance company, and request payments of benefits be made to Radiant Dermatology & Aesthetics, PLLC. I acknowledge that I am financially responsible for payment of services not covered by insurance.

Signature: _____ Date: _____

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Office and Financial Policies

Welcome and thank you for choosing Radiant Dermatology & Aesthetics for your medical care. We are committed to providing you with the highest quality medical care in an efficient and cost-effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

Initials:_____ **Insurance**: The patient is responsible for knowing their insurance benefits including their deductible and out- of-pocket expense. Copay, Deductibles and patient's financial portion including any balance will be collected at the time of service. You may be asked to reschedule your appointment for non-payment. We will gladly file your insurance claim on your behalf. We will not be involved in disputes between you and your insurance company regarding coverage and/or policy benefits. You are responsible for the timely payment on your account.

Initials:_____ **Cancellations:** Please call our office 24 hours in advance if you are unable to keep a scheduled appointment. If you do cancel within 24 hours, you may be charged a No Show Fee of $50.

Initials:_____ **Referrals:** Patients with an **HMO** policy need referrals to see any specialist. You may be required to go back to your primary care physician to obtain a referral for a specialist that we want you to see. This is an HMO guideline that we have no control of.

Initials:_____ **Patient Balances:** Please be prepared to pay the current visits as well as any past balances on your account. Copay, Deductible, Out-of-pocket expense and non-covered services will required at the time of service. For your convenience we take cash, check and credit cards.

Initials:_____ **Late Arrivals:** We do our best to have less patient wait time but when a patient arrives late, it is impossible to stay on schedule. If you arrive 15 minutes late you may be asked to reschedule your appointment to keep our schedule on time.

Initials:_____ **Dishonored Checks:** A $30 Return Check Fee will be assessed on all dishonored checks. If you have 2 dishonored checks on file, check payment will no longer be a payment option for you but will gladly accept cash or credit card payments on your future visits.

Initials:_____ **Collections:** You will be receiving at least 3 statements from our office for balances owed. Please ensure to make payment arrangements, if necessary, to keep your account current. If your address changes it is your responsibility to inform our office to update our records. Otherwise, your account will be turned over to collections when it is returned as a bad address. When your account is already in collections, you **may not** be seen until the account is paid in full at the collection agency.

Initials:_____ **Prescriptions:** It is the patient's responsibility to call the pharmacy 5 days prior to running out of medication. **Refills may take 2 – 4 business days to be refilled.**

I have read understand and agree to the above office and Financial/Office policies. I hereby attest that I have given and agree to provide current demographics and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient name:_____ DOB: _____

Signature:_____ Date:_____

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Cosmetic Interest Form

Dear Patient and Friend:

- If you are interested in any of our cosmetic products or services, please take a moment to fill out your contact information below. **If you would like to receive our monthly newsletter and special offers via email/text.**

Please Check One: Yes Please! _____ No Thank you _____

Name: _____ Date: _____

Email: _____

Home Phone: _____ Cell phone: _____

Preferred Method of contact: ____ Home phone _____ Cell Phone ____ Email _____Text
DOB _____ Male _____ Female _____

Please check any cosmetic services you are interested in learning more about:

- Cutera Excel V: Vascular & Pigmented Lesions
- Cutera Genesis: "Hollywood Glow"
- Cutera Excel V: leg veins
- Photo Facial Skin Rejuvenation (IPL)
- Laser Hair Removal
- Skin Care Products - Skin Ceuticals, NeoStrata, PCA Skin, or EltaMD, RDA Skin
- Dysport or Botox Injections
- Restylane, Restylane Silk, Restylane Lyft, Refyne & Defyne
- Sculptra (Full- Face Volume Correction)
- Customized facials and PCA Skin Chemical Peel
- Eclipse Micro needling: PRP, HA, GF
- Kybella (Upper Neck Fat Reduction)
- truSCULPT (Non- Invasive fat reduction and skin tightening)
- Smart Graft Hair Restoration Surgery
- PRP Scalp injections for hair loss/ Hair Growth Products/ Capillus laser light cap

HIPAA Privacy Authorization Form

This form is used for authorization for use or disclosure of PHI, protected health information.
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Patient Name:_____
Patient Date of Birth: _____

I _____ (name) authorize Radiant Dermatology and Aesthetics permission to all my health care and medical service providers and payers to disclose and release my protected health information described below to:

Name(s):	Relationship:	Phone Number:

Health Information to be disclosed (Check all that apply):

- ☐ My information is not to be released to anyone.
- ☐ My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing, for all conditions) OR
- ☐ My complete health record, as above, with the exception of the following information: (check as appropriate):
    - ☐ Mental Health Records
    - ☐ Communicable diseases (including HIV and AIDS)
    - ☐ Alcohol/drug abuse treatment
    - ☐ Other, please specify:
      _____

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- ☐ All past, present, and future periods, OR
- ☐ Date:_____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers in writing.)

_____ _____
Signature of Patient or Patient Representative Date

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Medical History & Medication Form

PATIENT NAME: _____ DOB: _____ DATE: _____

CHIEF COMPLAINT: Please describe the reason for visiting:

_____

_____

How Long: _____ Symptoms: _____ Treatments Tried: _____

MEDICAL HISTORY:

Past Medical History: *Please circle all that apply*

Anxiety	Breast Cancer	Hearing Loss	Lymphoma
Arthritis	Colon Cancer	Hepatitis/Liver Disease	Prostate Cancer
Artificial Joints	COPD	High Blood Pressure	Radiation Treatment
Asthma	Coronary Artery Disease	HIV/AIDS	Seizures
Atrial Fibrillation	Depression	High Cholesterol	Stroke
Bleeding Disorder	Diabetes	Thyroid Disease	NONE
BPH	End Stage Renal Disease	Leukemia	
Bone Marrow Transplant	GERD	Lung Cancer	

Other (Not Listed): _____

PREVIOUS SURGERIES: Please list surgery and dates, include any complications with anesthesia

_____

_____

Skin Disease History: *Please circle all that apply*

Actinic Keratosis (Precancers)	MOHS Surgery	Contact Dermatitis	Lupus
Basal Cell Carcinoma	Dry Skin (Xerosis)	Poison Ivy	Vitiligo
Squamous Cell Carcinoma	Eczema/Dermatitis	Hives	Rosacea
Melanoma	Asthma	Flaky/Itchy Scalp (Dandruff)	Hair Loss
Dysplatic Nevus (Abnormal Moles)	Hay Fever	Psoriasis	Acne

Do you wear sun screen?	Yes	No	If yes, what SPF? _____
Do you tan in a tanning bed?	Yes	No	If yes, how often? _____
How many times have you had a **blistering sunburn?** _____			
Do you have a **family history** of the following?			
Malignant Melanoma	Yes	No	
Dysplatic Nevi (Atypical Moles)	Yes	No	
Psoriasis	Yes	No	
Lupus	Yes	No	

MEDICATIONS: Please include any over the counter medications or supplements you are currently taking

_____

_____

_____

ALLERGIES:

_____

_____

_____

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ADDITIONAL QUESTIONS:

Are you a smoker?	Yes	No	How many years?	# per day?
Do you drink alcohol?	Yes	No	How often?	
Do you use drugs?	Yes	No	Type?	Frequency?
If 65 or older, have you received the pneumonia vaccine?	Yes	No		
What is your preferred language?				

HEALTHCARE PROXY:

Do you have a health care proxy, power of attorney and/or living will? **Yes**________ **No**________

Results:

If biopsy results are benign is it ok to leave a voicemail/text message? **Yes**________ **No**________

Patient Signature: ____ **Date:** ______________

ALERTS/CAUTIONS :

Allergy to Adhesive	Yes	No
Allergy to Lidocaine	Yes	No
Allergy to Latex	Yes	No
Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Do you have an artificial joint replacement?	Yes	No
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No

FEMALE SPECIFIC QUESTIONS :

Are you currently pregnant ?	Yes	No
Are you planning on getting pregnant?	Yes	No
Are you breastfeeding?	Yes	No

PREFERRED PHARMACY:

Pharmacy Name: ____ Phone Number: __________________________

Pharmacy Address: ________________________ City: __________________ State: _______ Zip Code: _______________

- -

Print Patient Name: ____ Date of Birth : ___________________________

Patient Signature: ____ Date : ____________________________