ANCILLARY SERVICES PATIENT REGISTRATION FORM

DEMOGRAPHICS

Full legal name: _____ Date of birth: _____ Social security number: ___-___-_____
Preferred name:_____ Legal sex:_____ Gender Identity:_____
Address: *Apt/Unit* *City* *State* *Zip Code*

_____

Primary phone: _____ Secondary Phone: _____ Email: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Address: *Apt/Unit* *City* *State* *Zip Code*

_____

Primary insurance: _____ Phone number: _____
Member ID number:_____ Group Number:_____
Claims mailing address: _____
Name of Insured: _____ Date of birth: _____ Social security number: ____-___-_____
Address: _____ Phone number: _____
Who is your primary care physician? _____ Phone number: _____
What is your preferred pharmacy (include name and location)?_____
What is your preferred laboratory (circle)? CPL QUEST LAB CORP SETON

**All labs will automatically be sent to CPL or Avero unless otherwise specified. Please note that we do not check insurance benefits or coverage for laboratory services.

Who were you referred by?_____
Reason for consultation:_____

_____

We will automatically enroll you for use of our online patient portal, which may include use of your email address to share practice news, specials, and health education. If you wish to decline, please indicate here: ☐ I DO NOT wish to use the patient portal. Signature: _____

PERSONAL MEDICAL HISTORY

Do you have a history of any of the following?

☐ Acne	☐ Hair loss (age first noticed:___)	☐ Cancer
☐ Eczema/rash	☐ Keloid/thick scarring	☐ Heart disease
☐ Hives	☐ Poor wound healing	☐ High blood pressure
☐ Sensitive skin/skin allergies	☐ Stretch marks	☐ Diabetes
☐ Abnormal moles/freckles	☐ Cold sores	☐ Hypoglycemia
☐ Sunburns	☐ Genital Herpes	☐ Migraines
☐ Excessive bleeding/nosebleeds	☐ HIV/Hepatitis	☐ Thyroid disease

☐ Other:_____

Have you ever had surgery or been hospitalized for an illness? YES NO
If yes:

Date	Type of surgery/illness	Location

FAMILY MEDICAL HISTORY

Do you have a family history of any of the following conditions?

Condition	Relations (ex: mother, brother x2 , maternal grandfather, paternal grandmother)	Living/Deceased
☐ Cancer		
☐ Hemophilia		

Initials:_____Date:_____

ALLERGIES:

Please list all known drug allergies and reactions:_____

_____

MEDICATIONS:

Please list any and all medications you are currently taking. Be sure to include any over-the-counter medications, including those for weight loss, pain relief, antacids, laxatives, and supplements.

Medication	Dosage	Frequency	Reason for Use
1.			
2.			
3.			

SOCIAL HISTORY

Do you drink alcohol?_____
Do you use tobacco products?_____
Do you use any illicit drugs?_____
Do you have any history of substance abuse?_____

WELLNESS QUESTIONS

Have you recently experienced any of the following?

- ☐ Fever/recent illness
- ☐ Excessive sweating
- ☐ Weight gain
- ☐ Weight loss
- ☐ Poor sleep
- ☐ Abdominal pain
- ☐ Unusual bleeding
- ☐ Urinary or fecal incontinence
- ☐ Rash/new sores

What was the date of your last menstrual cycle?_____
What is your current method of birth control?_____
Is there any chance that you could be pregnant?_____

If you are interested in facial services, please answer the following:

Have you ever used Accutain/Botox/Retin A? _____

What type of sunscreen and skin products do you currently use? _____

Have you ever had a chemical peel, microneedling, or other similar service?_____

Do you tend to tan or burn when exposed to the sun?_____

MEDICAL CLEARANCE FORM – STAFF USE ONLY

PMH/PSH/MEDS reviewed.

Discussed area(s) to be treated which is _____.

EXAM:
GEN: NAD, alert and oriented
SKIN of area being treated: no rashes, suspicious moles
ABD if being treated: Soft, NT, ND, no masses or hernia; No rectus diastasis noted
EXT: NT, no edema noted

This patient is medically cleared for _____.

Provider Name: _____ Provider Signature:_____ Date:_____

Initials:_____Date:_____

Aesthetic Health History Questionnaire

Patient Name: _____ DOB: _____ Date: _____

Please check all that apply to you for cosmetic reasons:

- ☐ Vitiligo
- ☐ Gold Therapy (gold sodium thiomalate)
- ☐ Compromised wound healing
- ☐ Unrepaired hernia in area of concern
- ☐ Pregnant and/or breastfeeding
- ☐ Coagulation disorder
- ☐ History of photosensitivity disorders or taking photo-sensitized medications (ex: doxycycline)
- ☐ Neuropathic disorder
- ☐ Impaired skin sensation
- ☐ Diabetic neuropathy
- ☐ Permanent implant. If so, location: _____
- ☐ Severe concurrent conditions, such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases
- ☐ Pacemaker or internal defibrillator, or any other metallic or electronic implant anywhere in the body
- ☐ Active condition in the treatment area, such as sores, psoriasis, eczema, or rash
- ☐ History of bleeding coagulopathies or use of anticoagulants in the last 10 days
- ☐ Medical or elective surgery within the past 3 months
- ☐ Use of Isotretinoin (Accutane®) within the past year
- ☐ Metal plates, screws or metal piercings
- ☐ Impaired immune system due to immunosuppressive diseases such as AIDS and HIV
- ☐ Autoimmune disorders or use of immunosuppressive medications.
- ☐ Laser resurfacing and deep chemical peeling within the last 3 months
- ☐ Active cold sores, Herpes Type I or Type II, or warts in treatment area (prophylactic treatment for facial sores is advised)
- ☐ Allergy to aspirin or salicylates
- ☐ Allergy to idebenone
- ☐ Current or history of skin cancer, or current condition of any other type of cancer, or pre-malignant moles
- ☐ Botox®/HA/collagen/fat injections/dermal fillers or other augmentation methods with biomaterial, before the product has been dissipated (up to 6 months), except Botox after binding to the facial muscles (3-7 days).
- ☐ Recent aminoglycoside antibiotics
- ☐ Neuromuscular disorders (e.g., myasthenia gravis, guilliane barre)
- ☐ Allergy to human albumin
- ☐ Allergy to lidocaine or the Gram-positive bacterial proteins
- ☐ Recent COVID-19 vaccine
- ☐ Recent dental work (2 weeks around fillers)
- ☐ Chemotherapy treatment

Initials:_____Date:_____

CONFIDENTIAL COMMUNICATIONS REGARDING YOUR HEALTH INFORMATION

The confidentiality of your personal health information is of the utmost importance to our office. Please indicate below any requests for restrictions on how we may communicate your personal health information and/or billing information.

☐ I authorize the release of my medical and/or billing information to:

Name(s) of person(s) who are permitted to discuss your personal health information and/or billing information

_____ _____

_____ _____

☐ I do not authorize the release of my medical and/or billing information to anyone other than myself.

This authorization will remain valid one year from the date listed below. It is the responsibility of the patient to notify the office of any changes to this information.

Printed name: _____ **Date:** _____

Signature: _____

If the patient is a minor (under 18), this form must be signed by a parent/guardian/legal representative:

Parent/guardian/legal representative signature:_____ Date:_____

CONSENT FOR TREATMENT

I authorize and direct Lisa M. Jukes, M.D. and her providers/mid-level providers (nurse practitioner/physician assistant)/assistants to perform quality care, including, but not limited to: diagnostic procedures and surgical and medical treatment(s), as may be necessary in their professional judgement.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the outcome of the procedures and/or treatments.

I acknowledge that, when medically appropriate, I may receive care from a mid-level provider or assistant.

I grant this consent without duress, confusion, or pressure from Lisa M. Jukes, M.D. and/or her staff, associates, or colleagues.

Printed name: _____ **Date:** _____

Signature: _____

If the patient is a minor (under 18), this form must be signed by a parent/guardian/legal representative:

Parent/guardian/legal representative signature:_____ Date:_____

Initials:_____Date:_____

Lisa M. Jukes, M.D., P.A. 5656 Bee Cave Rd, Ste B101, Austin, TX 78746 (512) 301 – 6767

HIPAA NOTICE OF PRIVACY PRACTICES

Effective, April 14th, 2003; Updated January 17th, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

1. Use and Disclosure of Protected Health Information Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital administration.
Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities, employee review activities, training of medical students, licensing, marketing, and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. The situations include: as required by law; public health issues as required by law; communicable diseases; health oversight, abuse, or neglect; Food and Drug Administration requirements, legal proceedings, law enforcement, coroner, funeral directors, organ donation, research, military activity and national Security, Worker's Compensation. Under the law, we must make disclosures to you and when required by the Secretary of the Department on Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance or on the use or disclosure indicated in the authorization.

2**.Your Rights** Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notification of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.
You have the right to request confidential communications from use by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
You have the right to request your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3.Complaints You may complain to use or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against your for filing a complaint.**

Signature below is only acknowledgement that you have received this Notice of Privacy Practices.

Print Name:_____ **Signature:**_____ **Date:**_____

Initials:_____Date:_____

Lisa M. Jukes, M.D., P.A. 5656 Bee Cave Rd, Ste B101, Austin, TX 78746 (512) 301 – 6767

FINANCIAL POLICY

Updated January 18th, 2017

1. **All payments are required at the time services are rendered.** If we are in network with your insurance company your copay, unmet deductible and/or coinsurance must be paid at the time of service. These amounts are only estimates of total financial responsibility and you may still be billed for additional amounts after the claim for your visit has been finalized. Federal law requires that we collect copays at the time of service; otherwise we can be charged with fraudulent business practices. Patients who may have difficulty paying at the time of service should ask about payment options you may be eligible for. All payment arrangements must be made prior to services being rendered.

   It is the patient's responsibility to know whether or not the provider of service is in network. The agreement with your insurance company is a contract between you and the insurance company. Please call the number on the back of your insurance card for this information. If we are not in network with your insurance or if you fail to get the necessary referral or authorization to see our providers, you will be responsible for the difference between physician charges and any out-of-network payments. If your plan states that you need a referral to see Dr. Jukes, it is your responsibility to obtain the referral from your primary care physician or insurance carrier, depending on your plan benefits, prior to services being rendered.

   Non-preventive concerns addressed at a wellness visit may not be covered in full. While many insurance plans cover well woman exams in full, any existing problems addressed at the same visit may be subject to copays and/or deductibles/coinsurance.

   Patients are responsible for verifying lab test coverage prior to testing. Some lab tests such as STD or hormone testing, lipid panels, and Vitamin D testing may not be covered by your insurance. Other tests may have a copay or charges towards your deductible or coinsurance. Many screening tests are not covered by Medicare. We do not verify any of this information. You are responsible for any lab fees not paid by your insurance.

   If you are undergoing surgery, it may be necessary, at Dr. Jukes' discretion, to use an assistant surgeon to safely complete your surgery. Any assistant surgeon fees not covered by your insurance will be your responsibility.

   If you are undergoing surgery, please note that Lisa M. Jukes, M.D. has a financial interest in Stonegate Surgery Center, LP and Arise Austin Medical Center.

   Patients without insurance coverage are eligible for a 30% discount off of our usual and customary billed fees. However, to receive this discount, payment must be made in full at the time of service.

2. **A 24 hour cancellation notice is required if you cannot keep your appointment**. There will be a fee of $100.00 applied to your account if we do not receive 24 hours' notice of a cancellation for an office-based appointment. 1 week's notice is required for the following in order to avoid the indicated fee: Pelvic Floor Rehabilitation - $150.00; LEEP, Hysteroscopy, Ablation, or Labiaplasty - $500.00; facility surgeries - $750.00. This fee must be paid in full before the missed appointment can be rescheduled. In addition, accumulating 3 "no-shows" without 24 hour cancellation notice for scheduled appointments will result in termination of the doctor-patient relationship.
3. For any balances on your account, you will receive an invoice requesting the payment that is due. **Please note that a finance charge of 3% will be accrued on any balance left unpaid for more than 45 days.** Failure to pay the outstanding balance will result in your account being sent to a collection agency. We will have no alternative but to terminate the doctor-patient relationship at this point. If your account is turned over to collections and you wish to reestablish care, you will be responsible for payment of the balance as well as a 40% charge to cover the costs of the collections agency. If there are unusual circumstances preventing you from paying your bill, please contact our financial coordinator Caroline at (512) 301 – 6767.
4. Please be aware that there is a $35.00 fee for the release of medical records to a patient. There is no fee for the release of medical records to another physician with written request from the patient. A minimum charge of $20.00 will be assessed for any paperwork to be completed by Dr. Jukes for your employer, school, attorney, etc. The exact fee will depend on the documentation required.
5. We do not accept the following insurance plans: Medicaid, Medicare, and Medicare Managed Care plans; Tricare Humana Military; Humana HMOs; BlueCross BlueShield HMOs; Aetna Advantage Plans (QHP). This is not an exhaustive list.
6. **On-time/paperwork completion policy:** We cannot consider your on time for your appointment until all necessary paperwork is completed in full. Paperwork is required for all new patients as well as yearly for established patients at their annual exams. If you do not have the required paperwork completed in full by the time of your appointment, it is possible that we may have to reschedule your appointment to a later time or different day if no later appointments are available. We reserve the right to charge you the appropriate cancellation fee if we are unable to see you for your appointment due to paperwork delays. You are always welcome to complete your paperwork ahead of time; all of your forms can be found on our website: lisamjukesmd.com.
7. **You may request a copy of this billing policy, an itemized statements of your account, or a written estimate of your out-of-pocket expenses for any service we provide at any time.**
8. Any questions or complaints regarding our billing policies can be directed to our financial coordinator Caroline at (512) 301 – 6767.

Please sign below to acknowledge this financial policy and agree to adhere to it.

Print Name:_____ **Signature:**_____ **Date:**_____