swan
DERMATOLOGY & AESTHETICS

Lori Swan, M.D., FAAD

Today's Date ______________

PATIENT INFORMATION:

Name: ____ M ☐ F ☐
(Last) (First) (Middle)

Address: ____

City: ______________________ State: ____________ Zip Code: ____________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Email: ______________________

Social Security: ______________________ Date of Birth: ______________________

Marital Status: [Married] [Single] [Other] Occupation: ______________________

Employer: ______________________ Employer Phone: ______________________

Emergency Contact: ______________________ Relationship: ____________ Phone: ____________

RESPONSIBLE PARTY / MAIN INSURED INFORMATION:

Name: ____ M ☐ F ☐

Address: ____

City: ______________________ State: ____________ Zip Code: ____________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________

Social Security: ______________________ Date of Birth: ______________________

Relationship to patient: ____

Employer: ______________________ Employer Phone: ______________________

PLEASE PRESENT ALL INSURANCE CARDS & PHOTO ID TO RECEPTIONIST.

(Rev. 9/15)

SWAN DERMATOLOGY and AESTHETICS
2020 Union Street, Suite 300 Lafayette, IN 47904

Phone (765) 446-0282 Fax (765) 446-8299

RECEIPT of NOTICE of PRIVACY PRACTICES

I,______________________________, hereby acknowledge receipt of the physician's Notice of Privacy Practices.
(Patient's Name or Patient Representative)
The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that *Swan Dermatology and Aesthetics* has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

____
Name of Patient *(Please Print)*

______________________________ ______________
Signature of Patient or Patient Representative if Patient is Unable to Sign Date

______________________ ______________________
Name of Representative (Please Print) Relationship of Patient Representative to the Patient *(Please Print)*

____
Reason the Patient is Unable to Sign *(Please Print)*

______________________________ ______________
Signature of Patient or Patient Representative if Patient is Unable to Sign Date

______________________________ ______________
Signature of Patient or Patient Representative if Patient is Unable to Sign Date

______________________________ ______________
Signature of Patient or Patient Representative if Patient is Unable to Sign Date

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______________________________ ______________
Signature of Patient or Patient Representative if Patient is Unable to Sign Date

Swan Dermatology & Aesthetics Prescription Refill Policy

In order to serve the needs of all our patients and uphold a high standard of medical care, Swan Dermatology & Aesthetics has instituted a prescription refill policy. We require a minimum of three (3) business days advance notice for prescription refill requests.

We will make every effort to handle your request quickly and efficiently. However, it requires chart review and your doctor's authorization before calling in a refill. Since your doctor is not in the office every day, it may take up to three (3) business days to discuss and process your request.

- ➛ Refill requests should be made during normal business hours, Monday – Thursday. Routine refills should not be requested through the answering service, as they will be unable to assist you. It is necessary to speak directly with a staff member at Swan Dermatology & Aesthetics before your refill request can be processed.
- ➛ When calling for a refill, please have the name, prescription number and dosage of the medication ready, along with the names of any other medications you are taking. You will be asked the status of the condition being treated.
- ➛ Certain medications require close monitoring, often necessitating lab work or an office visit prior to being refilled. Compliance with recommended follow-up visits is required in order to continue prescription refill requests. These requirements are in place in order to monitor for possible side effects and note the effectiveness of the medication.

Please understand this policy has been implemented to best serve you and your medical needs. Thank you for your cooperation in this matter.

______________________________	______________________________
Signature	Date
______________________________	______________________________
(If Minor, Guardian's Signature)	Date

Swan Dermatology & Aesthetics

2020 Union Street | Suite 300
Lafayette, IN 47904
p 765.446.0282 f 765.446.8299
swandermatology.com

PHOTO RELEASE FORM

I, ____________________, grant Swan Dermatology & Aesthetics and any associate affiliated with the Practice permission to capture photos before, during and/or after my treatment. I authorize the Practice to use these photographs for the purpose of medical records, marketing materials, and patient education.

I understand that these photographs will be used at my physician's discretion in the office, on the Practice's website, or in any marketing materials. I understand these images will be used to illustrate the treatment results and appropriate measures will be taken to ensure my identity is not revealed or compromised.

I do not expect compensation, financial or otherwise, for the use of these photographs. I release the Practice and its employees and representatives from any and all claims, actions, and liability related to the use of these photographs.

I understand that I may revoke this authorization at any time if provided in writing and delivered to the Practice.

Patient Name ____ **Date** ______________

Patient Signature ____

SWAN DERMATOLOGY AND AESTHETICS
COSMETIC SERVICES/PATIENT MEDICAL HISTORY
UPDATE EVERY 3 YEARS

A. Medical/Cosmetic History

Name:____________________ Age:__________ Date:________

How did you hear about us? (please circle) J&C Google SD&A Website Facebook

Friend/Family:__________ Physician:__________ Other:__________

Medications (including vitamins, herbal supplements, and over-the-counter medications):

____

Preferred Pharmacy:__________ Primary Care Physician:__________

Please list all product and medication allergies:__________

☐ Egg Whites ☐ Albumin ☐ Lidocaine ☐ Latex ☐ Any Vaccine

Please list your chronic medical problems:__________

History of peels/laser in the past? Yes No

If so, when and what type? __________

History of herpes or cold sore infection? Yes No

If so, how often? __________

History of Accutane? Yes No

If so, date of last treatment: __________

Skin Type: Dry Oily Normal Combination Sensitive Acne-Prone (Circle all that apply)

History of tanning bed use? Yes No

Contact Lenses? Yes No

Females Only
Regular Menstrual Periods? Yes No

Hormone replacement therapy? Yes No

Pregnant? Trying to become pregnant? Breast Feeding Yes No

Currently taking a contraceptive? Yes No

Current Skin Care Regimen:

Cleanser:__________ Moisturizer:__________

Toner:__________ Serums:__________

Retinoid:__________ Other:__________

B. Areas of Concern

Desired Services:____

What results do you hope to achieve?____

Do you have any special events coming up?_________________________ Dates:______________

What are you most interested in discussing today? (check/circle all that apply)

- □ Skincare Regimen
- □ Procedures for wrinkle reduction
  - □ Filler □ Botox □ Other:______________________
- □ Procedures to improve skin tone or lightening
  - □ HydraFacial MD
  - □ Laser Treatments (circle all that apply)
    - □ BBL □ MicroLaserPeel □ Profractional Resurfacing □ Laser Hair Removal
  - □ Chemical Peels
    - □ Lip & Eye Peel □ Beta □ TCA □ Obagi Blue Peel
- □ Non-Facial Procedures
  - □ Kybella □ Cool Mini □ CoolSculpting
  - □ Neck Rejuvenation □ Other:______________________

SWAN
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Lori Swan, M.D., FAAD

PATIENT AUTHORIZATION FORM

Patient Name: ______________________________ Date of Birth: ________________________

Initial **If the patient is a minor or student, the responsible party should initial where indicated.**

[ ] **TREATMENT**
Permission is hereby granted to my physician, Lori S. Swan, MD, or other designated healthcare provider to administer such examination, treatment, testing and procedures as are deemed necessary in the course of my care.

[ ] **INSURANCE**
I authorize any insurance carrier with whom I have a policy, that holds a contract with Swan Dermatology & Aesthetics to pay directly any medical benefits to my healthcare provider.
I understand that if Swan Dermatology & Aesthetics is not in network with my insurance, I should receive any reimbursement, or out of network benefits directly to me.

[ ] **MEDICARE**
Please fill out and sign the back side of this form

[ ] **CANCELLATION OF SCHEDULED APPOINTMENTS**
In the event I do not give Swan Dermatology and Aesthetics at least 24 hours notice to cancel a scheduled appointment or do not arrive for a scheduled office visit, I will be charged and expected to pay a cancellation or no show fee of $25.00 to $65.00 based on my appointment type.

[ ] **FINANCIAL AUTHORIZATION/OBLIGATION**
I understand that I am financially responsible for all fees for services rendered to the above listed patient. If I neglect to fulfill this responsibility, I understand I am legally responsible for any collection fees, including attorney fees and court costs incurred to obtain payment.

______________ ______________________________________
Date **Signature of Patient**

______________ ______________________________________
Date **Signature of Responsible Party (if the patient is a minor or student)**

______________ ______________________________________
Date **Print name of Responsible Party (if the patient is a minor or student)**

Medicare Patient Registration

Answer the questions below by placing a check in the appropriate column:

YES	NO	
☐	☐	Have you recently joined a Medicare Advantage Plan? If yes, identify: ______________________
☐	☐	Do you or your spouse work in a company which has more than 20 employees AND have coverage through the insurance at that job?
☐	☐	Are you covered by a HMO/PPO which makes Medicare secondary?
☐	☐	Is this illness covered by the VA (Veteran's Administration)?
☐	☐	Is this illness covered by the Federal Black Lung or End-Stage Renal?
☐	☐	Disease Program? If yes, please circle program above.
☐	☐	Is this illness due to an automobile accident?
☐	☐	Is this illness due to an injury at work?
☐	☐	Are you receiving Medicaid?

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare & Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment Regulations pertaining to Medicare assignments of benefits apply.

______________________________ ______________________

Signature as it appears on Medicare Card Date

If you have a supplemental policy to which your Medicare Carrier automatically "crosses over," we are required to keep a separate signature on file:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

______________________________ ______________________

Signature as it appears on Supplemental Card Date