29101 Health Campus Dr.
Bldg. 2, #300
Westlake, Ohio 44145
www.laserandskinsurgerycenter.net
(440) 871-0816 F
(440) 871-9832
(800) 884-6084

THE
Laser & Skin Surgery
CENTER

Renuka Diwan, M.D.

Thank you for choosing our office for your care. Enclosed is a brochure that will introduce you to Dr. Diwan and the services that are offered. On the reverse of the brochure are some general directions to help you locate our office. You will also find forms for you to complete at home and bring with you for your visit. Please bring a photo ID. Due to FTC regulations, we will not be able to see you without it. If your visit is cosmetic and requires a pre-payment, be sure to note the date on the enclosed pre-payment letter.

Please Note: *Please refrain from bringing young children to your appointment. Interruptions and distractions by the predictable and unpredictable nature of a child's needs make it difficult to perform a thorough consultation or procedure. Our staff cannot provide child supervision. Please find child care for your child outside our office. You will not be seen if you have a young child with you. Our experience over the years has led us to arrive at this policy and we appreciate your cooperation.*

Our office is situated in a pet-free building. Please leave your pets at home, with the exception of a seeing-eye dog.

If we can assist you further in any way, please contact one of our office associates at 440-871-9832. Should you need to change your appointment, please give us 48 hours' notice. We need timely notification to accommodate other patients. Without a notice of 2 business days for a cancellation, you will be charged $50.00. After your visit we would appreciate any comments, for they allow us to improve our services. We look forward to seeing you.

Sincerely,

The Laser & Skin Surgery Center

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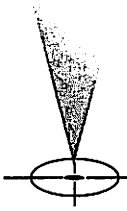


THE
Laser & Skin Surgery
CENTER

Renuka Diwan, M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, The Laser & Skin Surgery Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to The Laser & Skin Surgery Center's Notice of Privacy Practices, available in the office or on the website, for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Laser & Skin Surgery Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at *29101 Health Campus Dr., Ste. 300, Westlake, OH. 44145*

With my consent, The Laser & Skin Surgery Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, The Laser & Skin Surgery Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that The Laser & Skin Surgery Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to The Laser & Skin Surgery Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, The Laser & Skin Surgery Center may decline to provide treatment to me.

_____ Date_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian

RENUKA DIWAN, MD
REGISTRATION FORM

Name_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone (____) _____ Work Phone (___) _____

Cell Phone (_____) _____ Driver's License # _____
(REQUIRED)

Date of Birth _____ Age_____ Sex_____ SS#_____

Can we leave messages on an answering machine? ___Yes ___ No
Preferred mode of contact? ___Home ___Cell
Lab results may be relayed to: Myself___Spouse___Voicemail ___other _____

Due to privacy laws. We are required to verify your identity when you receive a call from a member of our staff to notify you of test results. You will be asked for your driver's license number for this purpose.

We occasionally offer promotions on cosmetic services and free skin cancer screenings. If you would like to be notified of promotions and events **please "like" us on Facebook**. You can also access your medical records electronically. If you are interested in doing so, please provide your email address and add lassc@sbcglobal.net to your "accept" list.
Your email address_____

*Ethnicity: Hispanic or Latino____ Not Hispanic or Latino____Prefer not to answer____
*Race: White_____ Other (please specify) _____
*Preferred language spoken at home_____
*Required by Affordable Healthcare Act

Occupation:_____ Level of Education: _____
Employer: _____
Employer's Phone Number: _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed_____
Spouse/Partner's Last Name: _____First Name: _____
Mother's Maiden Name: _____
Referred By: _____

Primary Care Physician: _____ Phone Number: _____
Address: _____

Preferred Pharmacy: _____ Phone Number: _____
Address: _____

CONTINUED ON BACK

EMERGENCY CONTACT---**REQUIRED**

Name (**OTHER THAN YOURSELF**) _____
Home Phone ( ) _____ Work Phone ( ) _____
Cell (___) _____
Relationship to patient? _____
Address same as Patient? ___yes ___no

Do you have a living will/advance health care directive? _____
If yes, please give us information necessary for your care in case of emergency._____
_____

PRIMARY INSURANCE

Insured's Name_____ Relation to Patient_____

Insured's SS# _____ Insured's Date of Birth _____

Insurance Company Name_____

Policy/ID# _____ Group Number _____

SECONDARY INSURANCE

Insured's Name_____ Relation to Patient_____

Insured's SS#_____ Insured's Date of Birth _____

Insurance Company Name_____

Policy/ID# _____ Group Number _____

Do you have coverage through a Group Health Plan through your current or former employer, of the current or former employer of a spouse or family member? If so, how many employees work for the employer providing coverage?
More than 20? ___yes ___no More than 100? ___yes ___no

Do you currently have COBRA? _____

Are you in Hospice? _____

PAYMENT POLICY: Due to greater costs incurred by seeing an out-of-network physician, it is your responsibility to confirm that Dr. Diwan is an in-network physician for your health plan, with your insurance company. For your convenience, our office will file claims with your insurance company for covered services. Payment for any services that are not paid by your insurance company are your responsibility. **Office co-pays and deductibles are due at the time of the visit.** If your insurance requires you to have a referral for seeing a specialist, please obtain a referral from your primary care doctor prior to your appointment with Dr. Diwan. Failure to do so will result in lack of insurance coverage and you will be responsible for our charges. There is a $10.00 fee for completion of any additional insurance forms that you wish to submit. There will be a $50.00 charge if you do not show for an appointment without notification 48 hours in advance. There will be a $100.00 no-show charge incurred for a laser treatment and a $600.00 charge for a missed Sculptra appointment.

I UNDERSTAND that there is a $25.00 charge for **returned checks**.

Payment for **services not covered by insurance** is required at the time of your visit. You will be asked to sign an Advanced Beneficiary Notice form for services that we believe will not be covered by Medicare, if applicable.

I AGREE that in the event my account is turned over to a collection agency or an attorney, for collection of unpaid balances, I will be responsible for all **additional costs** incurred in the collection of my debt.

I authorize the **release of medical information**, including pathology slides, necessary for treatment and to process this claim, and also authorize payment of medical benefits to the physician.

Please refrain from bringing young children to your appointment. Interruptions due to a child's needs distract from consultations and procedures. Our staff cannot provide supervision for children. Please find child care outside our office. Our experience over the years necessitates this policy and we appreciate your cooperation. Our office is in a pet-free building. Please leave your pet at home (with the exception of a seeing-eye dog).

Signature _____ Date _____

Aesthetic Patient Self-Assessment

Please complete this questionnaire to help us better understand your history, preferences, and concerns with respect of aesthetic treatments and procedures. Your responses will help us identify and recommend the most appropriate treatments and procedures for you.

Contact Information:

Name: _____

Please indicate your preferred method of contact: Cell Phone_____Home Phone_____E Mail_____

1. What is the main reason you came in for this consultation?

   _____

   _____

2. What aesthetic treatments and procedures, if any, have you had in the past?

   _____

   _____

3. If you have previously had any aesthetic treatments or procedures, were you pleased with the outcome?

   _____Yes _____No

   If no, what way were you dissatisfied?

   _____

   _____

4. Do you have any concerns about aesthetic treatments or procedures?

   _____Yes _____No

   If yes, please identify your concerns:

   _____

   _____

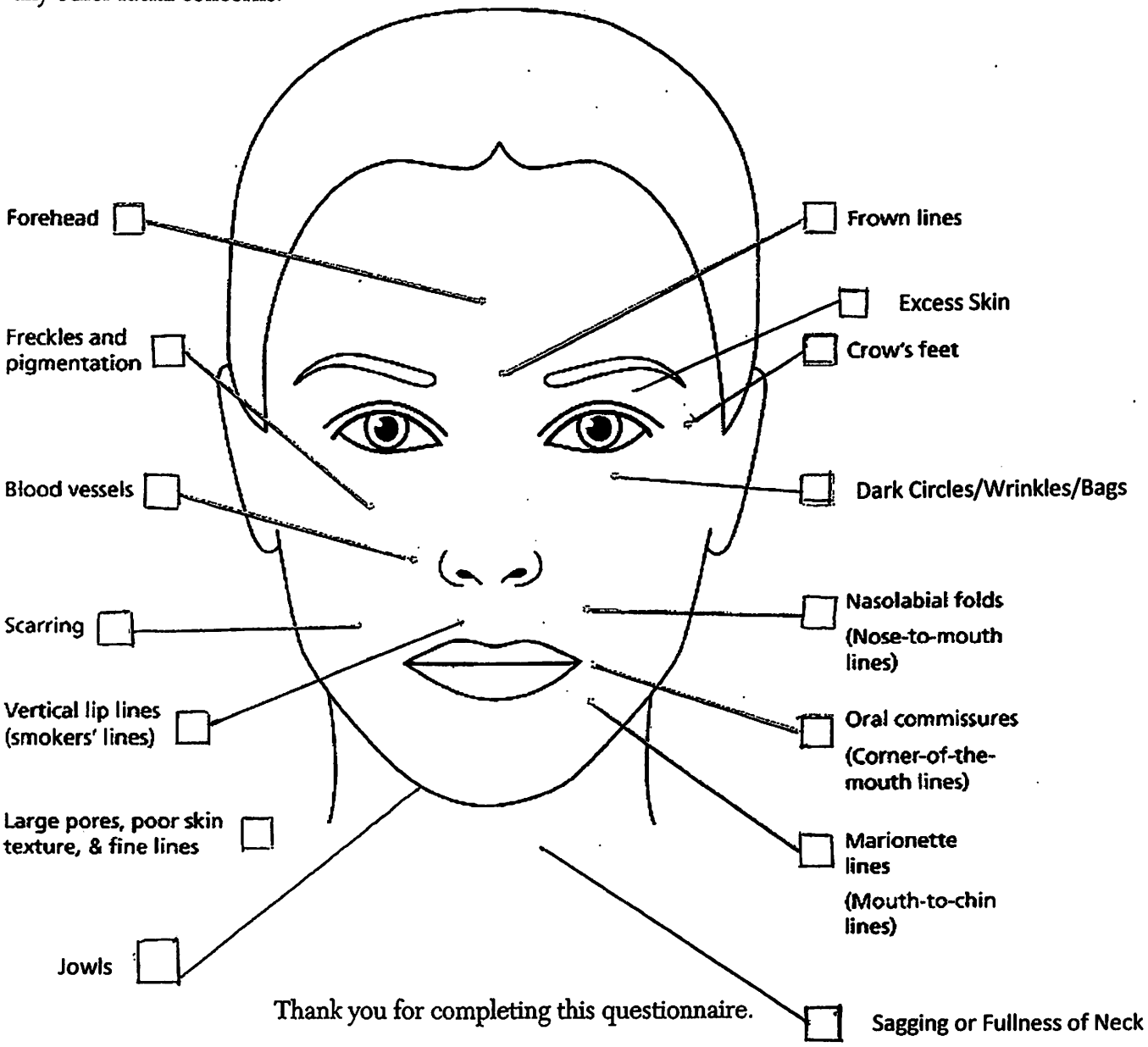
5. Please indicate your opinion on the following statement:

   I would prefer correcting my facial wrinkles and lines with a product that does not contain animal-derived ingredients. Please check your response.

   _____Yes _____No _____Not sure. I would like to discuss.

Facial Anatomic Representation

With respect to facial aesthetics, please highlight those areas of the face that bother or trouble you. In the boxes provided, please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome). Feel free to draw on the chart to identify any other facial concerns.



Thank you for completing this questionnaire.

Aesthetic Products, Treatments, and Procedures

Please let us know which of the following aesthetic products, treatments, and procedures interest you. Please check all that apply.

__Skin rejuvenation
__Topical wrinkle treat
__Microdermabrasion
__Dermal fillers (Restylane, Juvederm, etc.)
__Botulinum toxin A
__Acne scar treatment
__Chemical peels
__Laser resurfacing
__Laser treatments
__Professional skin-care products
__Professional skin care products
__Liver spot/Age spot correction
__Sunscreen Advice
__Facial plastic surgery
__Leg vein correction
__Hair removal
__Facial vein correction or removal
__Liposuction/Body contouring
__Eyelash enhancement
__Other (please specify):_____

_____

Cancellation Policy
Cosmetic Visits

Our office policy for cancellations or re-scheduling of appointments requires that patients give us at least two business days' notice. This allows us time to accommodate another patient and make the best use of our appointment times. Without a two day notice, there will be a $50.00 cancellation charge.

For certain specific procedures requiring special preparation or equipment, cancellation fees are higher due to the cost of such equipment. You will be informed of the cancellation fee for such appointments.

I,_____, understand that if I cancel or re-schedule an appointment with less than two business days' notice, I will be charged a $50.00 cancellation fee.

*Signed*_____

*Print*_____

*Date*_____