NicholsMD of Greenwich
BOUTIQUE CARE FOR BEAUTIFUL SKIN

NEW CLIENT REGISTRATION

We believe that you should feel beautiful, confident, and ready to live your best life, today and every day.

TODAY'S DATE _____ /_____ /_____

CLIENT NAME _____ _____
(first) *(last)*

DOB_____ /_____ /_____ AGE_____ GENDER _____ EMAIL _____

MAILING ADDRESS _____

CITY _____STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

OCCUPATION _____EMPLOYER _____

EMERGENCY CONTACT

NAME _____PHONE NUMBER _____RELATIONSHIP_____

PHARMACY NAME & CITY/STATE _____ PHARMACY NUMBER_____

PARENT/ RESPONSIBLE PARTY (if different from client)

NAME _____ _____
(first) *(last)*

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

EMAIL _____ DOB_____ / _____ / _____

WHOM DO WE HAVE THE PLEASURE OF THANKING FOR REFERRING YOU?

- **FAMILY/FRIEND?** YES NO NAME(S)_____
- **NICHOLSMD STAFF?** YES NO NAME(S)_____
- **MAGAZINE?** NEW BEAUTY GREENWICH MAGAZINE SERENDIPITY
- **ONLINE?** PLEASE CIRCLE ALL THAT APPLY:

TWITTER FACEBOOK INSTAGRAM LINKEDIN GOOGLE YELP YOUTUBE PINTEREST ZOCDOC
If you "googled" us, what were some of the words you typed in your google search? _____

- **ANOTHER PHYSICIAN'S OFFICE?** YES NO NAME OF PHYSICIAN: _____
- **MAGAZINE?** NEW BEAUTY GREENWICH MAGAZINE SERENDIPITY
- **OTHER REFERRAL (Please Explain):** _____

50 Old Field Point Road, Third Floor ♦ Greenwich, CT 06830 ♦ 203-862-4000
www.KimNicholsMD.com

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MEDICAL HISTORY

ARE YOU ALLERGIC TO ANY MEDICATIONS?

YES ☐ NO ☐

IF YES, PLEASE INDICATE THE NAMES OF MEDICATIONS: _____

PLEASE LIST ANY MEDICAL CONDITIONS YOU HAVE _____

PLEASE LIST ANY MEDICATIONS YOU CURRENTLY USE (include over-the-counter and topical medications, vitamins and herbal supplements):

_____

_____

WHAT IS THE PURPOSE OF YOUR VISIT TODAY? _____

PAST DERMATOLOGIC HISTORY

DO YOU HAVE A HISTORY OF SKIN CANCER OR ANOTHER SEVERE SKIN CONDITION?

☐ YES ☐ NO

IF SO, PLEASE DESCRIBE: _____

DO ANY CLOSE FAMILY MEMBERS HAVE A HISTORY OF SKIN CANCER OR A SEVERE SKIN DISEASE?

YES ☐ NO ☐

PLEASE DESCRIBE: _____

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COSMETIC QUESTIONNAIRE

PLEASE CHECK OFF ANY COSMETIC CONCERNS AND PROCEDURES YOU ARE INTERESTED IN DISCUSSING:

SPECIFIC AREAS OF CONCERNS

- ☐ FROWN LINES
- ☐ FOREHEAD LINES
- ☐ CROW'S FEET
- ☐ BROW LIFT
- ☐ SMILE LINES
- ☐ DROPPING CHEEKS
- ☐ SUNKEN EYES
- ☐ DARK UNDEREYE CIRCLES
- ☐ NOSE
- ☐ THIN LIPS
- ☐ SAGGING JOWLS
- ☐ THINNING LASHES
- ☐ UNWANTED FACIAL HAIR
- ☐ DOUBLE CHIN
- ☐ BROKEN CAPILLARIES
- ☐ HAIR LOSS
- ☐ UNWANTED MOLES
- ☐ BROWN SPOTS
- ☐ LARGE PORES
- ☐ UNEVEN SKIN TONE
- ☐ FACIAL REDNESS
- ☐ ACNE
- ☐ ACNE SCARRING
- ☐ STRETCH MARKS
- ☐ LOOSE, SAGGING SKIN
- ☐ STUBBORN FAT
- ☐ AGING HANDS
- ☐ EXCESSIVE SWEATING
- ☐ LEG VEINS/SPIDER VEINS
- ☐ INCONTINENCE
- ☐ VAGINAL LAXITY
- ☐ LOW ENERGY LEVELS

PROCEDURES OF INTEREST

- ☐ BOTOX, DYSPORT, XEOMIN
- ☐ FILLERS
- ☐ ULTHERAPY
- ☐ PRP-MICRONEEDLING
- ☐ PRP FOR HAIR LOSS
- ☐ COOLSCULPTING
- ☐ LIPOSONIX
- ☐ FRAXEL
- ☐ CO_2 LASER RESURFACING
- ☐ FEMININE REJUNIVATION
- ☐ SCLEROTHERAPY
- ☐ FACIALS
- ☐ CHEMICAL PEELS
- ☐ MICRODERMABRASION
- ☐ LED LIGHT THERAPY
- ☐ VITAMIN INJECTIONS

COMPLIMENTARY SERVICES

An **annual full-body skin examination** to screen for skin cancer is recommended. There is no additional charge for this exam over the initial office visit charge. The exam is performed with a gown and undergarments on. Please indicate if you want this exam performed.

YES ☐ NO ☐ *If no, please initial that you are aware that the current ASDS and AAD recommendation is that a total body skin exam should be performed every 2 years if >40 years old and annually if <40 years old.* _____

NicholsMD would like to offer a thorough assessment using our **SkinCeuticals SkinScope** to examine your skin for sun damage, dehydration, and excess oils. This unique LED technology will allow us to recommend a very personalized skincare regimen for you to help *prevent*, *correct* and *protect* your skin. Please indicate if you want this exam performed.

YES ☐ NO ☐

AUTHORIZATION, ASSIGNMENT AND ACKNOWLEDGEMENT

I hereby authorize the release to my medical carriers of all information needed to substantiate payment for my medical care. A photostatic copy of this signature may be used as a substitute for the original.

_____ _____

CLIENT/RESPONSIBLE PARTY SIGNATURE DATE

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NOTICE OF PRIVACY PRACTICES CONSENT

CLIENT NAME (First/Last): _____

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 CLIENT 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 Patient may condition receipt of treatment upon the execution of this**

AUTHORIZATION, ASSIGNMENT AND ACKNOWLEDGEMENT

My signature below indicates that I have read and understand this consent in its entirety, that my questions have been adequately answered, and that a copy of the Notice of Privacy Practices is available to me upon my request.

CLIENT/RESPONSIBLE PARTY SIGNATURE	STAFF SIGNATURE	DATE

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FINANCIAL POLICY AT NICHOLSMD OF GREENWICH

FINANCIAL POLICY

Payment is due in full at the time of service for consultations, examinations, and procedures. We accept cash, checks, and all major credit cards. As a courtesy, we also offer **Care Credit ™**, a credit card financing program for medical and cosmetic procedures. Ask us about it if you are interested.

Dr. Nichols and NicholsMD of Greenwich are considered out-of-network providers for all insurance plans. Therefore, payment is due in full at time of service. As a courtesy, we would be happy to print or email your itemized superbill to you, so you can submit it to your insurance company. If you're insurance company accepts out-of-network services, they will reimburse you according to their policy. ***It is your responsibility*** to know your insurance company's out-of-network policies.

Laboratory and Pathology Services will bill you and/or your insurance plan directly for laboratory services rendered (blood work, cultures, biopsy specimens, etc.).

Our office will keep your credit card on file in order to expedite checkout transactions, charge non-refundable deposits towards specific appointments, and/or cancellation etiquette breaches. **The credit card number is kept in a secure program in our system.** Please fill out the information below:

Type of Credit Card: Visa_ MasterCard_____ American Express_____

Credit Card Number: _____ Exp. Date: _____/_____

All consultation fees, follow-up appointment fees, deposits, and procedures done at NicholsMD are considered services rendered, and thus, are **non-refundable**.

CANCELLATION ETIQUETTE

NicholsMD of Greenwich has a **24-hour cancellation policy.** ***All appointments cancelled less than 24 hours prior to the appointment will be charged the full fee of the visit of $175.***

My signature below indicates that I am fully aware of the financial and cancellation policies of NicholsMD of Greenwich. And I accept full responsibility for all expenses incurred. In addition, I grant authorization to release any information required to obtain payment of medical benefits.

I have read and understand this statement in its entirety and my questions have been adequately answered.

CLIENT/RESPONSIBLE PARTY SIGNATURE	STAFF SIGNATURE	DATE

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CLIENT PHOTOGRAPHY RELEASE FORM

I, _____, understand that taking medical photographs is an important part of patient care. Thus, I authorize NicholsMD of Greenwich, Dr. Kim Nichols and staff representatives, to take photographs of my body for medical purposes. These photographs will ONLY be used for my patient care.

CLIENT/RESPONSIBLE PARTY SIGNATURE	STAFF SIGNATURE	DATE