

TODAY'S DATE ____/____/____

NEW CLIENT REGISTRATION

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

CLIENT NAME _____
(first) (last)

HOW MAY WE ADDRESS YOU? (i.e NICKNAME) _____

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)

HOME PHONE _____ CELL PHONE _____

EMAIL _____ RELATIONSHIP TO CLIENT _____

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

- FAMILY/FRIEND? YES NO NAME(S) _____
- NICHOLSM D STAFF? YES NO NAME(S) _____
- EQUINOX? YES NO NAME(S) _____
- MAGAZINE? NEW BEAUTY GREENWICH MAGAZINE SERENDIPITY
- ONLINE? PLEASE CIRCLE ALL THAT APPLY:
TWITTER FACEBOOK INSTAGRAM LINKEDIN GOOGLE YELP YOUTUBE HEALTHGRADES ZOCD OG
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: _____
- OTHER REFERRAL (Please Explain): _____

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: _____

COSMETIC QUESTIONNAIRE

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

SPECIFIC AREAS OF CONCERNS

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

PROCEDURES OF INTEREST

- BOTOX, DYSPORT, XEOMIN
- FILLERS
- ULTHERAPY
- PRP-MICRONEEDLING
- PRP FOR HAIR LOSS
- COOLSCULPTING
- LIPOSONIX
- FRAXEL
- CO₂ LASER RESURFACING
- FEMININE REJUVENATION
- 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

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

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 your 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. We also require non-refundable deposits for specific treatments and Saturday appointments.**

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

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