Annette C. LaCasse, D.O.

Dear Valued Patient:

Thank you for choosing Commerce Institute of Skin, the office of Dr. Annette C. LaCasse. We look forward in seeing you for your future appointment.

In order for us to serve you better, please take the time to fill out the enclosed new patient forms. You may fax them back to us prior to your appointment or bring them in with you on the day of your appointment.

If you would rather fill out the forms when you arrive, please allow at least **15 minutes** prior to your appointment time to expedite your service. **Please bring with you a copy of your insurance card and photo identification.**

We look forward to helping you with all of your skin-related concerns and thank you again for choosing Commerce Institute of Skin.

Warm Regards,
Dr. Annette C. LaCasse

Commerce Institute of Skin

Annette C. LaCasse, D.O.

PATIENT INFORMATION

Allergies to Medication:______________________________________ DATE:_______________________________

____ BIRTHDATE:__________________________

FEMALE: PREGNANT? YES ☐ NO ☐ S.S.#_________________________________

PLEASE PRINT CLEARLY

PATIENTS FULL NAME____ AGE____________SEX_______________

Last First Middle Initial

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

ADDRESS____

CITY____STATE______________ZIP________________

PHONE ( )_________________________OCCUPATION____

EMPLOYED BY____PHONE ( )____________________________

REFERRED BY______________________________________SPOUSE'S NAME____

CELL PHONE ( )____________________________

PERSON RESPONSIBLE FOR ACCOUNT____

ADDRESS____

CITY____STATE______________ZIP________________

PHONE ( )______________________________________RELATIONSHIP____

CELL PHONE ( )____________________________

PRIMARY INSURANCE INFORMATION: BC/BS ☐ MEDICARE ☐ OTHER ☐

SUBSCRIBER NAME____DATE OF BIRTH_______________________

CONTRACT #____

GROUP #____COVERAGE CODE #___________________________

INSURANCE ADDRESS____

EMPLOYER____PHONE ( )_____________________________

Commerce Institute of Skin

Annette C. LaCasse, D.O.

PATIENT INFORMATION

SECONDARY INSURANCE INFORMATION: BC/BS ☐ MEDICARE ☐ OTHER ☐

SUBSCRIBER NAME____DATE OF BIRTH_______________________

CONTRACT #____

GROUP #____COVERAGE CODE #___________________________

INSURANCE ADDRESS____

EMPLOYER____PHONE ( )___________________________

I UNDERSTAND THAT THE OFFICE OF DR. LACASSE MAY BILL THE INSURANCE COMPANY FOR ANY PROCEDURES/SURGERIES RENDERED. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS WITHIN THE CALENDER YEAR. I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCES.

SIGNED____

Medical History

Full Name:(Print) ___________________________________ **Date of Birth:** _____________________________

Reason for today's visit (chief complaint): ____

____

Current or past problems with (Review of systems)

	Yes	No	
General Health	___	___	___________________________
Eyes	___	___	___________________________
Ears/Nose/Throat/Mouth	___	___	___________________________
Heart	___	___	___________________________
Lungs	___	___	___________________________
Stomach/Bowel	___	___	___________________________
Kidney's	___	___	___________________________
Arthritis/Muscles/Joints	___	___	___________________________
Skin	___	___	___________________________
Headaches/Seizures	___	___	___________________________
Psychological Disorder	___	___	___________________________
Thyroid/Diabetes	___	___	___________________________
Blood/Bleeding Disorder	___	___	___________________________
Allergic/Immunologic	___	___	___________________________

Women:

Are you pregnant? Yes __ No __ Could you be pregnant? Yes___ No___ Planning to become pregnant? Yes __ No __

Abnormal periods? ____ Date of last period: ___________________ Excessive facial and/or body hair? ________

Family History: (Past family and social history)

Mother: ___ Living ___ Deceased ___ Age **Father**: ___ Living ___ Deceased ___ Age

Check the following medical conditions that have occurred in your **family**:

Disease	Mother	Father	Blood Relative
Allergies	___	___	___
Arthritis	___	___	___
Asthma	___	___	___
Cancer	___	___	___
Diabetes	___	___	___
Eczema	___	___	___
Hay fever	___	___	___
Heart Disease	___	___	___
High Blood Pressure	___	___	___
Lung Disease	___	___	___
Malignant Melanoma	___	___	___
Psoriasis	___	___	___
Skin Cancer	___	___	___
Tuberculosis	___	___	___

Any family history of skin cancer or other cancer? If yes please describe: _______________________________________

____

Commerce Institute of Skin

Annette C. LaCasse, D.O.

Insurance: ________________

Today's Date:________________

Patient Form

Patients Full Name: ____________________________

Birthdate/AGE _____________ / ____

Phone Number: __________________**Cell**_________________

Referred by: ____________________

Address: ________________________
____
____

Allergies: ______________________
____
____

Email: ___________________________

Occupation: _____________________

Please mark any of the following you have had in the past or currently have:

___ Diabetes
___ High Cholesterol
___ Thyroid Disease
___ Herpes Infection
___ High Blood Pressure
___ Heart Attack
___ Angina/Chest Pain
___ Congestive Heart Failure
___ Other Heart Disease
(Specify ______________________)
___ Hiatal Hernia
___ Liver Disease
___ Stomach Ulcers
___ Disease of the Colon
___ Hemorrhoids
___ Tobacco Use (How much _____________)
___ Alcohol Use (How much ______________)
___ IV Drug Use

___ Kidney Disease
___ Bladder Problems
___ Prostate Problems

___ Asthma
___ Chronic Bronchitis
___ Emphysema
___ Allergies
___ Pneumonia
___ Other Lung Disease
___ Exposure to TB
___ Headaches
___ Stroke
___ Seizures/Epilepsy
___ Broken Bones/Accidents
___ Head Injury
___ Fainting
___ HIV Testing Results____________

___ Depression
___ Anxiety
___ Psychiatric Illness

___ Arthritis
___ Osteoporosis
___ Gout
___ Back Problems
___ Eye Problems
___ Ear Problems
___ Muscle Weakness
___ Blood Transfusions
___ Bleeding/Clotting Disorder
___ Anemia
___ Cancer (Specify_____________)
___ Reaction to Local Anesthetic
___ Abnormal Skin Healing
___ Reaction to Substances Applied to skin

___ Cosmetic Surgery (What Type: ____)

Is there anything else you would like to tell us about your past or present medical history? ___________________
____

Social History:

Do you live alone? Yes ___ No ___ Married: N___ Y___ Spouse's Name:______________________

Of Children _____

Name and ages of Children: ____________________________ _____
____________________________ ______
____________________________ ______
____________________________ ______

Hobbies/Leisure activities: ___________________________

Employed By: ____________________________

Emergency Contact:

Name: ________________________ Phone Number: ____________________ Relationship: ____________

Patient Signature ____ Date_______________________

Commerce Institute of Skin

Annette C. LaCasse, D.O.

MEDICATION LIST

Full Name:	Pharmacy:
Birthdate:	Pharmacy Phone Number:

Allergic To/Describe Reaction:	Allergic To/Describe Reaction:

List all prescription and over-the-counter (non-prescription) medications such as vitamins, Aspirin, Tylenol, and herbals (ex: Ginseng, Gingko Biloba, St. John's Wort) Include prescription meds taken as needed, (ex. Viagra, Nitroglycerin).

Other Medicine				Dermatology Medicine			
Date	Name of Medication	Dose	Stopped	Date	Name of Medication	Dose	Stopped

Commerce Institute of Skin

Annette C. LaCasse, D.O.

Insurance Provider List

Here are the more common insurances we accept:

Aetna
BCBS PPO
Cofinity
DMC Care
Health Plus PPO
Medicare
Medicare Plus Blue
Medicare Aetna
Medicare Humana
Priority Health HMO
Priority Health PPO
United Health Care
Cigna HAP
HAP PPO AND HMO (excluding closed networks with Henry Ford, DMC and Genysis Hospitals)

Understanding Insurance Language

To help with some of the common insurance lingo, we have listed several of the most common definitions that we feel are important to be aware of.

Copay
The amount an insured person is expected to pay for a medical expense at the time of the visit.
Coinsurance
More generally, a sharing of risk between the insurer and the insured. Also called copay.
Maximum Benefit
An annual maximum benefit amount is the maximum dollar amount that an insurer has to pay for all healthcare services for the insured during a year.
Deductible
A portion of a claim to be paid by the insured before any payment is made by the insurer.
Coordination of Benefits
Benefits under one plan are coordinated with benefits from another insurance plan (that covers the same benefits), so payments won't be duplicated. All families must submit COB information annually, if using benefits, in order to expedite the claims paying process.

For any questions regarding your insurance please contact our office.
Please check with your insurance company for benefit coverage.

Commerce Institute of Skin
Annette C. LaCasse, D.O.

Patient Questionnaire

In order to serve your needs to the fullest, please circle the following topics you would like to discuss or would like further information on.

Skin Cancer Information

Botox

Restylane, Perlane, Juvederm, Radiesse, and Other Fillers for Wrinkles and Lines

Laser Resurfacing & Photo rejuvenation

Psoriasis / Eczema

Lesion Removal

Vein Treatments

Scar Treatments

We offer a complimentary consultation for the following services. Please complete if you would like to schedule a consultation with an Aesthetician.

Microdermabrasion

Chemical Peels

Commerce Institute of Skin

Annette C. LaCasse, D.O.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR DR. ANNETTE LACASSE, D.O. PC.

Dear Patient:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

INTRODUCTION

At Dr. Annette LaCasse, D.O. P.C., we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your patient protected health information. This notice is effective April 14th. 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit Dr. Annette LaCasse, D.O. P.C., a record of your visit is made. Typically, this record contains information about your visit including your patient examination, diagnosis, test results, and treatment as well as other information. Your chart often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication with the health, professionals involved in your care.
- Legal document outlining and describing the care you received.
- A tool that you or another payer (your insurance company) will use to verify that services billed was actually provided.
- An education tool for medical health providers. A source for medical research.
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards.
- A source of data for planning and/or marketing.
- A tool we can reference to ensure the highest quality of care and patient satisfaction.

Understanding what is **in** your record and how your health information is used helps you to insure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of the information to other individuals.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR DR. ANNETTE LACASSE, D.O. PC.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and receive a copy of your protected health information at our standard charge for copying.
- The right to appoint a personal representative to receive communication regarding your condition and care. (Personal representative for minor patient will be assumed to be parent or legal guardian unless notified otherwise.)
- The right to amend or submit corrections to protected health information.
- The right to receive an accounting of how and to whom your protected health information had been disclosed.
- The right to receive a printed copy of this notice.

OUR RESPONSIBILITIES

Dr. Annette LaCasse, D.O. P.C. is required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to requested restrictions.
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and/locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reasons for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR DR. ANNETTE LACASSE, D.O. PC.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your information for treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment: Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We will use your information for regular health operations: Your health information may be used as necessary to support the day-to-day activities and management of Dr. Annette LaCasse, D.O. P.C. For example: information on the services that you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates: In some instances, we have contracted separate entities to provide service for us. These “associates” require your health information in order to accomplish the task that we ask them to provide. Some examples of these “business associates” might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family: There are times when a parent or guardian of a minor cannot view or receive a patient medical record. Michigan law provides for the confidential treatment of a minor upon that minor’s request for sexuality matters, contraception, sexually transmitted diseases, mental health concerns and substance-use disorders, among other conditions.

Research/Teaching/Training: We may use your information for the purpose of research, teaching, and training.

Healthcare Oversight: Federal law requires us to release your patient information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public Health Reporting: Your patient health information may be disclosed to public health agencies as required by law.

Annette C. LaCasse, D.O.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR DR. ANNETTE LACASSE, D.O. PC.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

Law Enforcement: Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

In Connection with Judicial and Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of the court or administrative tribunal as expressly authorized by such order or in response to a signed authorization (in a format approved by the Michigan Court Administrator).

For Worker's Compensation: The practice may release your health information to comply with worker's compensation laws or similar programs.

Other uses and disclosures: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or privacy practices of Dr. Annette LaCasse, D.O. P.C. please contact:

OFFICE MANAGER
Dr. Annette LaCasse, D.O. P.C.
8906 Commerce Road, Suite 5 Commerce, MI. 48382
(248) 363-5555

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official or, you may file a complaint with the Office for Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F, HHH Building
Washington, D.C. 20201

DR. ANNETTE LACASSE, D.O. P.C.
8906 Commerce Rd., Suite #5
Commerce Twp., MI 48382
248-363-5555

HIPAA

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

NAME (Print)________________________________Birthdate______________

Signature____

Date____

Authorization to release information to my primary physician: ____yes ____no
Dr. ____________________________
Address:________________________
City:___________________________
Phone:__________________________

I allow my medical information to be disclosed with:

☐ Spouse Name____

☐ Child Name____

☐ Caregiver Name____

☐ Other Name____

☐ Guardian Name____

IF YOU WISH TO HAVE A FAMILY MEMBER RECEIVE INFORMATION REGARDING YOUR MEDICAL RECORDS, YOU MUST SIGN THE **MEDICAL RELEASE AUTHORIZATION FORM.**

I UNDERSTAND THAT THE OFFICE OF DR. LACASSE MAY BILL THE INSURANCE COMPANY FOR ANY PROCEDURES/SURGERIES RENDERED. I AUTHORIZE THE RELEASE OF ANY M EDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS WITHIN THE CALENDER YEAR. I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCES

********SIGNED:**____