

**Aistheta Reno Medical Skin Care Center**

6630 S. McCarran Blvd., Ste. A-9

Reno, NV 89509

Ph: 775-829-1212 – Fax: 775-829-1179

DATE: \_\_\_\_\_

**PATIENT INFORMATION**

**Patient Name:** \_\_\_\_\_  
(last) (first) (middle)

**Physical Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**Mailing Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Birth date:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_ **Sex:** F M **Marital Status:** S M D W

**If a Minor, Parents' Names:** \_\_\_\_\_  
(mother) (father)

**Emergency Contact:** \_\_\_\_\_  
(name) (home phone) (cell phone) (work phone) (relationship)

**Preferred Contact Method:** \_\_\_\_\_ **E-Mail Address:** \_\_\_\_\_

**How did you hear about us:** \_\_\_\_\_

**EMPLOYMENT INFORMATION - PATIENT**

**Occupation:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Employer:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**SPOUSE/PARENT**

**Spouse/Parent's Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**Name of Subscriber:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Birth date of subscriber:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Employer Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**Insurance Company:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**SECONDARY INSURANCE**

**Name of Subscriber:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Birth date of subscriber:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Employer Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**Insurance Company:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

I am consenting to be treated. By agreeing to receive care, you are consenting generally to other medical treatments such as laboratory test and minor procedures that your physician may order. I understand that co-payments are due at time of visit. I authorize release of any medical information necessary to process my medical claim. I realize that I am responsible for any balance my insurance company does not pay/cover.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have no insurance and agree to pay my balance in full at each visit.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**New Patient History Questionnaire**

Your Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

In order to best serve your needs and personalize your care, please take a few moments to complete this form.

Primary reason for today's appointment: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Have you received treatment for this problem before today? \_\_\_\_\_

If yes, please describe (including any non-prescription creams you have tried): \_\_\_\_\_

Do you have other skin problems you would like evaluated? \_\_\_\_\_  
(Note: These problems may require a second appointment. If you want more than one problem treated during this visit, your insurance company may refuse payment).

Do you want a full skin exam? *Please note that this requires completely undressing.*  Yes  No

Please list your current medications: \_\_\_\_\_

Please list any allergies to medications: \_\_\_\_\_

Do you have or have you ever had any of the following:

- |  |  |   |   |  |
|--|--|---|---|--|
| <input type="checkbox"/> ANEMIA                  | <input type="checkbox"/> ARTHRITIS       | <input type="checkbox"/> ASTHMA/HAY FEVER | <input type="checkbox"/> BLEEDING DISEASE | <input type="checkbox"/> CANCER        |
| <input type="checkbox"/> CORONARY ARTERY DISEASE | <input type="checkbox"/> DIABETES        | <input type="checkbox"/> ECZEMA           | <input type="checkbox"/> HAIR LOSS        | <input type="checkbox"/> HEART DISEASE |
| <input type="checkbox"/> HEADACHES               | <input type="checkbox"/> HEPATITIS       | <input type="checkbox"/> HIV              | <input type="checkbox"/> HIVES            | <input type="checkbox"/> HYPERTENSION  |
| <input type="checkbox"/> KELOIDS                 | <input type="checkbox"/> KIDNEY DISEASE  | <input type="checkbox"/> LIVER DISEASE    | <input type="checkbox"/> MELANOMA         | <input type="checkbox"/> LUPUS         |
| <input type="checkbox"/> MIGRAINE                | <input type="checkbox"/> NEUROL. DISEASE | <input type="checkbox"/> PEPTIC ULCER     | <input type="checkbox"/> PREVIOUS SURGERY | <input type="checkbox"/> PSORIASIS     |
| <input type="checkbox"/> RECENT WT GAIN/LOSS     | <input type="checkbox"/> SEIZURES        | <input type="checkbox"/> SKIN CANCER      | <input type="checkbox"/> TUBERCULOSIS     |  |

**FEMALES:** ARE YOU CURRENTLY: PREGNANT Y / N CURRENTLY TAKING: BIRTH CONTROL Y / N  
DO YOU HAVE AN IRREGULAR MENSTRAL CYCLE Y / N

Have any blood relatives have or ever had any of the following:

- |                                    |                                    |                                   |                                    |                                      |
|------------------------------------|------------------------------------|-----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> ASTHMA    | <input type="checkbox"/> CANCER   | <input type="checkbox"/> DIABETES  | <input type="checkbox"/> ECZEMA      |
| <input type="checkbox"/> HAIR LOSS | <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> MELANOMA | <input type="checkbox"/> PSORIASIS | <input type="checkbox"/> SKIN CANCER |

Is there anything else about your medical history which may be important for the doctor to know?

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AISTHETA/ROBERT J. RILEY, M.D.**

**PATIENT CONSENT FORM**

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, or 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 and 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 Consent. Aistheta provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that:**

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- Aistheta has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Aistheta reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information but Aistheta 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
- Aistheta may condition receipt of treatment upon the execution of this Consent.

**This Consent was signed by:**

\_\_\_\_\_  
Printed Name – Patient or Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if other than patient)

**Witness:**

\_\_\_\_\_  
Printed Name – Practice Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## RELEASE OF INFORMATION AUTHORIZATION

By signing this release, you are authorizing Robert J. Riley, M.D./Aistheta Reno Medical Skin Care Center to release your medical information to the individuals you have named below (spouse, a child, relative, friend). If you do not wish to have your medical information released to anyone but you, please fill in your name, sign and date the document.

I \_\_\_\_\_ (patient/parent/guardian) authorize Robert J. Riley, M.D./Aistheta Reno Medical Skin Care Center to release medical information for \_\_\_\_\_ (patient) to the following individuals:

1) \_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Phone number

2) \_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Phone number

3) \_\_\_\_\_  
Name Relationship

\_\_\_\_\_  
Phone number

\*This authorization may be revoked at any time with written notice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## **Our Financial Policy**

*Here at Aistheta/Reno Medical Skin Care Center it is our mission to provide quality medical care in a professional and caring environment.*

*As a patient, the best action you can take to ensure that your billing is accurate is provide us with current contact and billing insurance information at each visit. With your cooperation, you should be able to receive all the benefits offered to you by your insurance plan(s), allowing our staff to do what they do best – concentrate on your skin care needs.*

1. Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. We accept cash, check, Visa, MasterCard, AMEX and Discover.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a copayment at the time of your visit.
4. We are not contracted with all insurance companies. We will prepare and send the claim however, out of network benefits will apply. Your insurance company may not pay any or only a portion of the claim. You will be responsible for any uncovered portion.
5. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
6. Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” and denies a submitted claim you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of patient (or responsible party)

Date

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Please print the name of the patient

  
**Aistheta**  
Reno Medical Skin Care Center

Dear Patient:

Your fee is based on the time I spend with you during your visit, the complexity of your medical condition, and any treatment I provide. But proper attention to your care also requires that I – or members of my staff- spend additional time beyond that which we spend with you in the office. Such time may be used to:

- 1) Create or maintain your permanent medial record.
- 2) Review, interpret, and document all lab test results and communicate those results – orally or in writing to you.
- 3) Prepare and mail consultation reports and letter.
- 4) Consult via phone about your case with referring or consulting physicians and other health care provider.
- 5) Prepare referral letters to additional specialists, as needed.
- 6) Prepare patient educational materials.
- 7) Conduct medical research relevant to your case.
- 8) Communicate with pharmacies about your prescriptions that you need.
- 9) Complete insurance applications and claim forms.
- 10) Conduct utilization review negotiations with insurance companies.
- 11) Draft letters of necessity to obtain medical services, instruments, or prescriptions that you need.

All these activities add to our cost of doing business. Still, we are committed to providing you the best possible care at the lowest cost. We hope this explanation of our fees has been helpful. With you, our patient, we look forward to a lasting and healthy relationship.

Sincerely,



Robert J. Riley, M.D.