SOCAHCENTER
SKIN OF CULTURE AND HAIR CENTER

Patient Name: _____ **Date of Birth:** _____ **Email:** _____
Home Phone: _____ **Cell Phone:** _____ **SSN:** _____
Home Address: _____**City**_____**State**_____**Zip**_____
Sex: Male/Female/In-Transition _____ **Marital Status:** Single/Married/Divorced/Widow(er)
Employer Name: _____ **Occupation:** _____
Pharmacy Name & Address:_____
How did you hear about us:

Google search	Walk-In	People you need to Know Magazine
Facebook	Radio Station	Sheen Magazine
Instagram	Best Self Magazine	Youtube
Event/Patient Name _____	Barber/Stylist Name_____	Doctor Referral Name_____

Please list your medical conditions: _____
Please list your medications or supplements: _____
_____
Please list your allergies to medicines: _____
Please list your environmental or material allergies: _____
Please list your personal history of skin cancer (type, location, date, treatment)? _____
_____
Please list your immediate family history of skin cancer (type)? _____
What is your typical daily diet?
a. Breakfast _____
b. Lunch _____
c. Dinner _____
d. Water _____
f. Sugar _____
Tobacco use? Yes No **Alcohol use?** Yes No **How much** _____ **How often** _____
How much time do you commit to working out (circle one) **Daily Weekly None How many hours?**_____

WOMEN: (circle one) **Are you pregnant or currently trying to become pregnant?** Yes No
Are you breastfeeding/pumping/nursing? Yes No

Please circle all areas you would like to discuss today or at future visits:

Acne	**DPN/Mole Removal**	**Nail Infections**
Blackheads	**Skin Cancer Screening**	**Ingrown Hairs**
Oily Skin	**Ripped/Torn Earlobe Repair**	**Platelet Rich Plasma**
Dry Skin	**Laser Hair Removal**	**Filler**
Eczema	**Hair Loss/ Alopecia**	**Botox**
Psoriasis	**Scalp Micro-Pigmentation/ SMP**	**Chemical Peel**
Anti-Aging Regimen	**Keloid Treatment**	**Discoloration**
Kybella (double chin treatment)	**IPL Laser (red and brown spots)**	**Fraxel (Laser Skin rejuvenation)**
Hair Transplant		

No Show / Cancellation Policy

Confirmation calls, emails, or text reminders are considered a courtesy. We are not responsible for voicemails that are full and phone numbers that are disconnected. Patients are responsible for maintaining their appointment dates. There is a fee of **$50** for all appointments and **$100** for procedure appointments that are missed or cancelled and a fee of **$25** when rescheduled without a 24 hour notice. These fees are expected to be paid prior to your next appointment.

_____ _____ _____

Patient/Legal Guardian's Printed Name **Patient/Legal Guardian's Signature** **Date**

Acknowledgement: Notice of Financial Responsibilities (In Notebook and online)

I am a patient of Skin of Culture and Hair center. I hereby acknowledge receipt of SOCAH Center's Notice of Financial Responsibilities and Merchant agreement. Copies of this document are available in the office and online at www.socahcenter.com.

_____ _____ _____

Patient/Legal Guardian's Printed Name **Patient/Legal Guardian's Signature** **Date**

Consent for Leaving Messages

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific medical information on my voicemail or answering machine, I need to give permission for SOCAH Center to do so. I can revoke this permission in writing at any time.

I give my permission for messages to be left on my phone number(s) below:

Cell # _____ Home # _____ Work #_____

☐ I prefer not to have voice mail messages from the clinic

Regarding the following: ☐ Appointment Reminders/Account Balances ☐ Treatments

Appointment Reservation Fee For Insurance & Cash Patients

I understand that there is a $50 fee to reserve time for an office visit and a $100 fee to reserve time for an in office procedure.

_____ _____ _____

Patient/Legal Guardian's Printed Name **Patient/Legal Guardian's Signature** **Date**

Patient Acknowledgement Receipt of Privacy Notice (In Notebook and online)

I,_____, hereby affirm that I have had the opportunity to read a copy of the *Notice of Privacy Practices* from **Skin of Culture and Hair Center**. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my health-care provider which is available at any time in the office and online at www.socahcenter.com. I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

_____ _____ _____

Patient/Legal Guardian's Printed Name **Patient/Legal Guardian's Signature** **Date**

Photograph & Video Release Form (Optional)

I hereby grant permission to the rights of my image, likeness and sound of my voice as recorded on audio or videotape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for the following purposes:

- Conference Presentations
- Educational Presentations or Courses
- Informational Presentations
- Online Educational Courses
- Educational Videos

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes. If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.

_____ _____ _____

Patient/Legal Guardian's Printed Name **Patient/Legal Guardian's Signature** **Date**

ONLY FILL OUT THIS PAGE IF YOU HAVE INSURANCE

Legal Assistant of Benefits and Designation of Authorized Representative

For The Release of Medical and Health Plan Documents For The Claims Processing & Reimbursement

Policy Holder Name_____ Policy Holder DOB_____

Insurance name_____ Policy #_____ Group #_____

Patient's Relationship to policyholder: Self ☐ Spouse ☐ Dependant ☐ Other ☐_____

I hereby instruct and direct above named insurance company to pay by check made out and mailed to:
Nikki D Hill MD LLC dba Skin of Culture and Hair Center
2296 Henderson Mill Rd Suite #300
Atlanta, GA 30345

If my current policy prohibits direct payment to the medical practice henceforth represented as Skin of Culture and Hair Center or Nikki D. Hill MD LLC, or any of the provider(s). I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. **This is a direct assignment of my rights and benefits under this policy and designation of authorized representative.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.
A copy of this Assignment shall be considered as effective and valid as the original.

- **I hereby authorize the above medical practice and the associated provider(s) to release all medical information necessary to process my claims under HIPPA** to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims, claim appeals, grievances, and securing payment of benefits. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.
- I authorize the above named provider(s) and medical practice to deposit insurance checks in my name.
- I authorize the above named healthcare provider(s) and medical practice to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I also agree that any fines levied against my insurance company will be paid to Nikki D Hill MD LLC or **Skin of Culture and Hair Center** for acting as my personal representative.
- In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee healthcare benefits coverage, and hereby assign and convey directly to the above name healthcare provider(s) and Skin of Culture and Hair Center and Nikki D. Hill MD LLC, as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. Unless revoked, this assignment is valid for all administrative and judicial review under PPACA, ERISA, Medicare and applicable federal and state laws.

CHECK BOX: ☐ I have read and fully understand this agreement.

_____ _____ _____

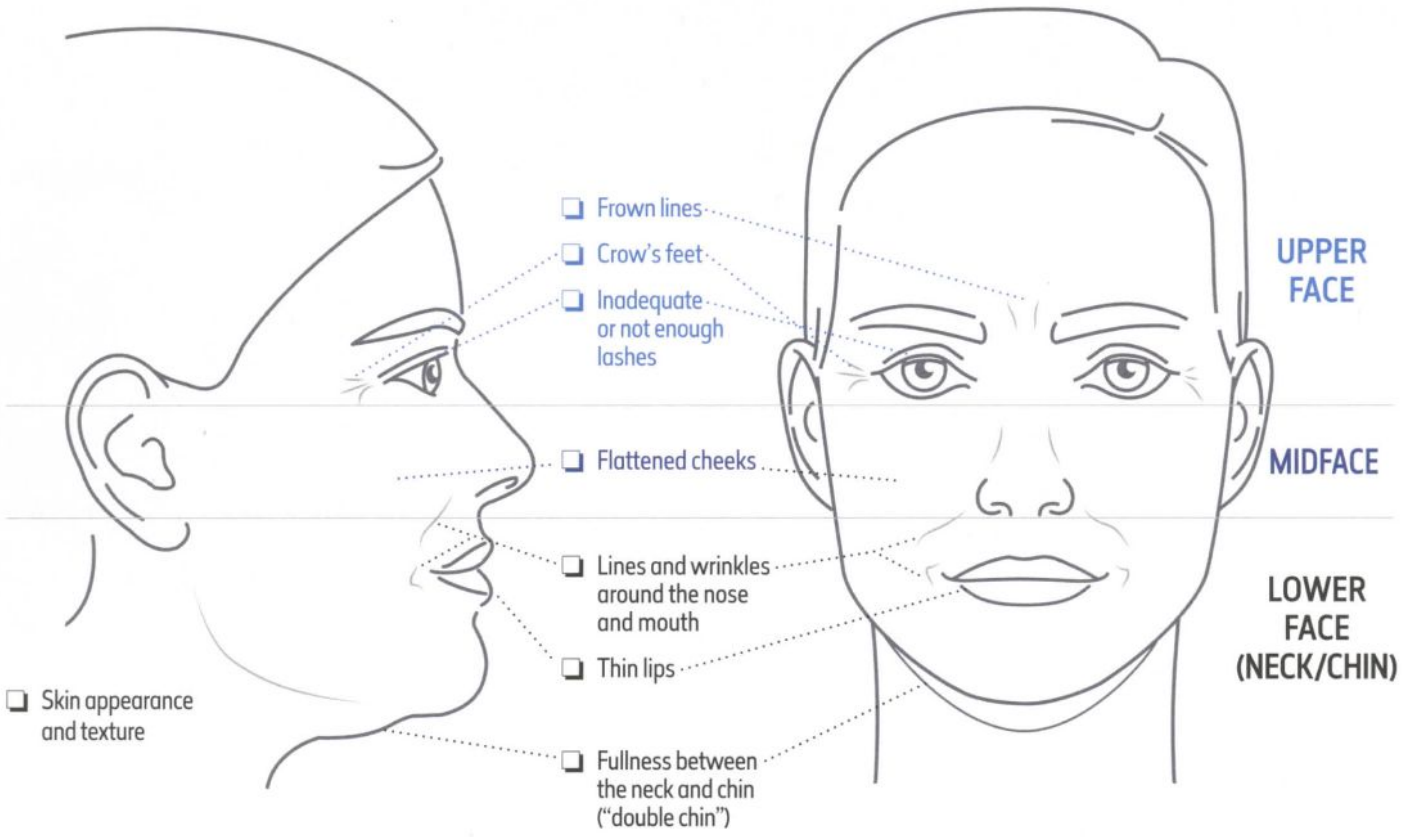
Signature of Insured **Printed name of Insured** **Date**

Optional:

Telemedicine consent form: If you are unable to make your follow up appointments in person and would like to schedule future appointments using a HIPAA-compliant video conference call between you and Dr. Hill, please ask for telemedicine consent form.

ONLY FILL OUT FOR AESTHETIC SKIN VISITS

What areas concern you?



Areas of concern:

ONLY FILL OUT IF THIS IS A HAIR LOSS VISIT

ALOPECIA WORKSHEET

Name _____

1. When was the last time you had no worries or concerns about your hair?_____
2. Have you noticed thinning of scalp hair? (circle one) **YES** **NO**
3. Have you noticed increased shedding of scalp hair? (circle one) **YES** **NO**
4. Are you experiencing hair breakage? (circle one) **YES** **NO**
5. Do most of the hairs you shed have a white root? (circle one) **YES** **NO**
6. Do you have any scalp symptoms? (circle any that apply) **Itching** **Tenderness** **Scaling/Sores** **Other** _____
7. List all family members with a history of hair loss or thinning as well as the age of onset:_____
8. Do you have a history of iron deficiency or anemia? (circle one) **YES** **NO**
9. Do you have a history of thyroid problems? (circle one) **YES** **NO** (if **Yes**) Are you currently undergoing treatment? _____
10. During the 6 months before the hair loss began, did you experience any of the following? (circle any that apply)

    Weight Loss **Pregnancy** **Surgery** **Change in Diet** **Illness** **Other** _____

11. **MANDATORY** Please write your hair journey. Include onset of symptoms or hair changes, who you saw for treatments, types of treatments (if they did or did not work), and dates. Also include any home or OTC treatments you tried at home._____

12. Have you had a scalp biopsy in the past? _____
13. What were the results? _____
14. What is your current hair regimen? **Wash Frequency** _____ **Conditioning Frequency** _____

    Straightening/Heat Frequency _____ **Chemical Relaxer/Perm/Hair Color** (circle one) **YES** **NO**

    (If **YES)** **How is chemical relaxer/perm applied?** **Home / Salon** **How is hair color applied?** **Home / Salon**

    Name of Chemical Relaxer/Perm/Hair Color _____ (If **NO)** (date of last chemical) _____

Women

15. Have you gone through menopause/change of life? (circle one) **YES** **NO** (if **Yes**) At what age_____
16. Have you had children? (circle one) **YES** **NO** Dates of birth: _____
17. Do you have a history of miscarriages? **YES** **NO** Dates: _____
18. Were there any problems with your pregnancy? _____
19. Are your menstrual cycle regular? (circle one) **YES** **NO** (if **YES**) Last menstrual cycle _____

ONLY FILL OUT IF YOU ARE AN ELIGIBLE MEDICARE/MEDICAID PATIENT

SOCAHCENTER
SKIN OF CULTURE AND HAIR CENTER

2296 Henderson Mill Rd Suite 300 Atlanta, GA 30345
Phone (404) 474-2301 Fax (888) 622-1751

Advance Beneficiary Notice of Noncoverage

Patient Name _____ **Date** _____

Medicare/Medicaid will not pay/reimburse for my visit and procedures at SOCAH Center and I understand I cannot submit a claim for reimbursement purposes. Medicare/Medicaid does not pay/reimburse for opted out or non-participating providers, which includes Dr. Nikki Hill.

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Medicare/Medicaid will not reimburse for out- of- network services, procedures, or office visits

PLEASE CHECK BOX BELOW:

☐ I want the office visit and procedures that are performed at SOCAH Center. I understand with this choice I am responsible for payment, and I cannot submit a claim to see if Medicare/Medicaid will pay.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice.

_____ _____

Patient Signature **Date**