LEITHAUSER SKIN INSTITUTE

Name: _____ Occupation: _____

DOB: ___/____/_____ Age: _____ Sex: _____ Referred by:_____

Primary Care Physician: _____

Preferred Pharmacy: _____ Email Address: _____

Primary Insurance: _____ Secondary: _____

PAST MEDICAL HISTORY: (circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Covid-19 Vaccine
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism (high)
Hypothyroidism (low)
Leukemia
Lung Cancer
Lymphoma
Pneumonia Vaccine
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE

PAST SURGICAL HISTORY: (please list): NONE

_____

_____

SKIN DISEASE HISTORY: (circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Carcinoma
Blistering Sunburns
Other: _____
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Carcinoma
Cancer
NONE

Do you wear sunscreen? YES NO If yes, what SPF? _____ Do you tan indoor/outdoor? YES NO

Do you have a family history of melanoma? YES NO If yes, which relative(s)? _____

MEDICATIONS: (Please list all current medications/dose) – Or give a copy to the front desk staff to enter in manually

_____

_____

ALLERGIES: (please list all allergies to medications)

_____

SOCIAL HISTORY:

Do you smoke? Yes__ No__ If yes, how much? _____ **If no**, have you smoked in the past? Yes__ No_

Do you drink alcohol? Yes___ No___ If yes, _____drinks per day/week/month

Do you have a family history of cancer (other than skin)? YES NO If yes, type of cancer(s)? _____

Which relative(s)? _____

REVIEW OF SYSTEMS: Do you **CURRENTLY** have any of the following? Circle **Y for YES** or **N for NO**

GENERAL:			
Fever	Y N	**NEUROLOGICAL:**	
Weight Loss	Y N	Headaches	Y N
Blurred Vision	Y N	Seizures	Y N
Sore Throat	Y N	**RESPIRATORY:**	
ENDOCRINE:		Chronic Cough	Y N
Thyroid Problems	Y N	Shortness of Breath	Y N
CARDIOVASCULAR:		Wheezing	Y N
Chest Pain	Y N	**HEMATOLOGY:**	
Swelling of Extremities	Y N	Abnormal Bleeding	Y N
GASTROINTESTINAL:		**INTEGUMENTARY:**	
Abdominal Pain	Y N	Problems with Healing	Y N
Bloody Stool	Y N	Problems with Scarring	Y N
Bloody Urine	Y N	Rash	Y N
MUSCULOSKELETAL:		**PSYCHIATRIC:**	
Joint Pain	Y N	Anxiety	Y N
Muscle Pain or Weakness	Y N	Depression	Y N

ALERTS: (circle all that apply)

Allergy to Adhesive
Allergy to Topical Antibiotics
Artificial Joint Replacement
Defibrillator
Pacemaker
Latex Allergy
Rapid heart with epinephrine
Allergy to Lidocaine
Artificial Heart Valve
Blood Thinners
MRSA
Pregnant or trying to get pregnant
Breastfeeding

Require antibiotics prior to a dental/surgical procedure Reason: _____

Race: _____ or DECLINE Ethnic Group: _____ or DECLINE

Preferred Language: ENGLISH or Other: _____

PATIENT SIGNATURE: _____ Staff Initials _____

Patient Name:_____Patient Date of Birth:_____

LEITHAUSER SKIN INSTITUTE

5199 N. Royal Drive
Traverse City, MI 49684
Laurel Leithauser, MD
Rachel Zenner, FNP-C
Natalie Gabel, RN

HIPAA CONSENT FORM

By listing the persons below, I am authorizing any employee of The Skin Cancer and Dermatology Center to release information contained in my patient records to the individuals listed below, only under the conditions listed below:

☐ Do not release any information to anyone.

☐ I authorize information to be released to (PLEASE PRINT NAMES & RELATIONSHIPS):

_____

_____

Primary Care Provider:_____

Without expressed written revocation, this authorization will remain in effect from the date of signature.

I acknowledge that I have been offered a copy of The Skin Cancer and Dermatology Center's Notice of Privacy Practices explaining my rights and permitted uses and disclosures regarding my protected health information.

PATIENT SIGNATURE: DATE:

_____

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INSURANCE SIGNATURE ON FILE CONSENT FORM

I certify that the information given by me for insurance and/or Medicare payment is true and correct.

I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits to Dr. Laurel Leithauser and Rachel Zenner on my behalf for any services and materials furnished. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer of agency shown, and authorizes my provider to act as my agent, as above.

PATIENT PRINT: DATE:

PATIENT SIGNATURE: DATE:

WITNESS SIGNATURE: DATE:

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CONSENT TO BE PHOTOGRAPHED – OFFICE USE ONLY

I consent for medical photographs to be taken of me by the staff or representatives of The Skin Cancer and Dermatology Center. I understand that the images will be placed in my medical record and may be used for a variety of purposes, including monitoring my response to treatments and confirming lesion site. By consenting to these medical photographs, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

I also give permission for the transfer of these photographs via a non-encrypted email exclusively for the purposes of third-party diagnostics, treatment and continuing medical care (for example, communication with my primary care physician).

Refusal to consent to photographs will in no way affect the medical care I will receive.

If I wish to withdraw my consent in the future, I may do so with a written request.

PATIENT PRINT: DATE:

PATIENT SIGNATURE: DATE:

WITNESS SIGNATURE: DATE:

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NO SHOW POLICY CONSENT FORM

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, patients who do not show up for their appointment without a call to cancel at least 24 hours before the appointment time will be considered as NO SHOW.

The Skin Cancer & Dermatology Center has the right to charge a fee of $50.00 for all missed appointments ("no shows"). No Show fees will be billed to the patient. This fee is not covered by insurance and must be paid in full prior to your next appointment.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

PATIENT PRINT: DATE:

PATIENT SIGNATURE: DATE:

WITNESS SIGNATURE: DATE:

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CONSENT AND AUTHORIZATION FOR SURGICAL PROCEDURES

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of Laurel Leithauser, MD or Rachel Zenner, FNP-C. This may include but is not limited to laboratory procedures (including diagnostic testing such as lab draws and skin biopsies), medical and surgical treatment or procedure(s) (including wart treatments, cryotherapy, electrocautery and destruction, surgical removals, or excisions), or other services rendered during my visit with Dr. Laurel Leithauser, Rachel Zenner, FNP-C, or Natalie Gabel, RN, at The Skin Cancer and Dermatology Center.

To ensure that you understand all aspects of your visit, we encourage you to ask any questions regarding any procedures prior to them being performed. Dr. Leithauser, Rachel Zenner, Natalie Gabel, and staff will answer any questions and discuss any procedures and concerns with you regarding the following:

- Benefits of the proposed procedure
- The way the treatment or procedure is to be performed
- Alternative treatment options
- Probable consequences of not receiving the treatment
- Risk and side effects involved with the procedure
- Potential for additional incurred charges
- The right to withdraw informed consent at any time, in writing

Should a biopsy/culture be performed, or any other procedure in which a sample or section of your skin is removed, the specimen will be sent to an outside pathology lab (typically Pinkus/Aurora, St. Joseph Mercy, Munson, or CTA) for an accurate diagnosis, unless otherwise recommended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges. Billing questions regarding pathology lab charges should be addressed with the pathology lab itself. A staff member from The Skin Cancer and Dermatology Center will call you in approximately 7-10 days to inform you of your results.

I acknowledge that some medical diagnoses (such as warts, pre-cancerous, irritated moles) will require multiple treatments with one or more methods that may change throughout the course of treatment according to the provider's treatment recommendation. I understand that each office visit and procedure will be billed accordingly.

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With any procedure, there are risks involved which include, but are not limited to, the following:

- PAIN: Some mild discomfort is experienced when the area is first anesthetized with the numbing medication. You may experience some mild discomfort during the procedure if the numbing medication has worn off in a particular location. This is easily remedied by immediately giving more anesthetic in that area. After the procedure some discomfort will be experienced at the surgical site. This is easily controlled with pain medications for a few days.

- INFECTION: Any time that the skin is injured an infection is possible. The rate of infection is very low. Some patients will receive postoperative antibiotics to prevent an infection. If you feel that your wound is infected after surgery, please call our office immediately.

- BLEEDING: When you leave our office, you will have a pressure bandage applied to your wound. Bleeding is always possible after surgery. Most cases of postoperative bleeding are easily stopped by applying pressure for twenty minutes over the site. If this does not work, please call our office immediately.

- SWELLING: After surgery you should expect some swelling where your surgery was performed and around the wound as well.

- HEMATOMA: A hematoma is a collection of blood that forms under the skin. This results from bleeding that occurs after the surgery. A "lump" forms under the skin, which is dried blood. If this occurs, call our office immediately.

- SCAR FORMATION: Any time that the skin is injured a scar will form. Some scars are more noticeable than others, but a scar is always present. A scar will form after your surgery. Hypertrophic and keloidal scarring are possible. If you have a history of bad scarring, please advise us at the time of your visit. The cosmetic appearance following surgery is unpredictable.

- WOUND DEHISCENCE: This means that your wound has broken back open after it has been repaired with sutures. It is very important to take it easy after your surgery so that unnecessary strain is not placed on the wound. This is an uncommon complication.

- FAILURE OF FLAP OR SKIN GRAFT: After your surgery is completed, we will need to repair the wound. Some patients are repaired with either a flap or skin graft. A flap is when skin is borrowed from a nearby site to close the defect. A skin graft is when a piece of skin is taken from one site and transplanted to another. A possible complication is the failure of either of these to take at the new site. Smoking is a documented risk for this complication so if you are a smoker, it is recommended that you discontinue smoking for one week before and after the procedure.

- TEMPORARY OR PERMANENT NERVE DAMAGE: The primary goal of your surgery is to completely remove the lesion. To accomplish this, it is sometimes necessary to damage a nerve. Nerve damage can be temporary or permanent. Recovery usually takes six months or more, and rarely can require additional surgery. Nerve damage may be limited to a loss of sensation or may include paralysis.

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- DISTORTION/ALTERATION OF SURROUNDING ANATOMIC STRUCTURES: The repair or healing of surgical wounds may distort the appearance of adjacent structures. Our goal is to completely remove your skin cancer—and then concern ourselves with the function and appearance of surrounding anatomic structures.
- TEMPORARY OR PERMANENT HAIR LOSS: Since the primary goal of your surgery is to completely remove the lesion, it is sometimes necessary to damage hair-bearing skin, such as the scalp. The resulting hair loss can be temporary or permanent.
- RECURRENCE: Recurrence is possible if the lesion is not completely removed. We will do everything we can to remove the lesion in its entirety, but since they grow microscopically, it is possible that the entire lesion is not removed.

I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at The Skin Cancer and Dermatology Center. I do not impose any limitations on The Skin Cancer and Dermatology Center and its staff. I understand that I should discuss any questions or concerns with Dr. Leithauser, Rachel Zenner, or Natalie Gabel prior to any procedure. Therefore, with my signature, agree to have any necessary procedures performed.

PATIENT PRINT: DATE:

PATIENT SIGNATURE: DATE:

WITNESS SIGNATURE: DATE: