KEY LASER INSTITUTE
Center For Cosmetic Regenerative Medicine

9755 SW Barnes Road Suite 155
Portland, Oregon 97225
(503) 291-1953

Patient Registration – Please Print Clearly

Date: _____

First Name: _____ MI: _____ Last Name: _____

I prefer to be called: _____

Date of Birth: _____ /_____ / _____ Sex: Female Male Other

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ May we leave a message on this phone? Y/N

Cell Phone: _____ May we leave a message on this phone? Y/N

Email Address: _____

May we email your Treatment Plan to this email address? Y/N

Preferred Contact Method: _____ (Home or Cell Phone?)

Emergency Contact Name: _____

Relationship: _____ Emergency Contact #: _____

How did you hear about us? _____
(Thank your friend! If another patient referred you to us – you both get a $50 reward. Don't worry – you'll remain anonymous. Ask us about our referral program for details.)

What is your primary reason for today's consultation? _____

_____

_____

Current Skincare Regimen/Concerns: _____

_____

_____

Preferred Pharmacy: _____

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Patient History

Current Health Status

1. List of Allergies:

   _____

2. Are you scheduled for or have you had any recent dental, medical or aesthetic procedures?

   _____

3. Do you have any upcoming events and/or trips planned? If so, when?

   _____

4. Do you have any active skin conditions or infections?

   _____

5. Are you pregnant or breastfeeding?

   _____

6. Please list all current medications and/or recent antibiotic use:

   _____

Procedural/Surgical History

1. Have you had any facial/oral surgeries and/or facial implants?

   _____

2. Have you ever fainted or been told you had a "vasovagal" response?

   _____

3. Do you get cold sores?

   _____

4. Have you had any recent vaccinations?

   _____

5. Have you ever had a complication with a cosmetic procedure?

   _____

Past Medical History

Y/N Neurological Disorders (Migraines, Bell's Palsy, Trigeminal Neuralgia, Myasthenia Gravis, etc.)

Y/N Heart Disease/Disorders

Y/N Breathing Problems

Y/N Bleeding or Clotting Disorders

Y/N Difficulty with Speech or Swallowing

Y/N Vision or Eye Problems (Glaucoma)

Y/N Auto-immune Diseases

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Communicating with you

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must give us an alternative address or other method of contacting you. **Some method of contact must be provided.**

We will not ask why you are making your request, and will make efforts to accommodate all reasonable requests.

I, _____ give my permission to Key Laser Institute physicians and employees to communicate information related to my health, as indicated below.

Please check all boxes that you give Key Laser Institute permission to use for our communications:

□ You may contact me by telephone Phone Number:_____ □ You may leave a message/voice mail Phone Number:_____
□ You may contact me by mail
□ You may contact me through email

If you give permission for us to communicate with anyone else, please complete the list below:

Name/Phone Number	Relationship	Options
1.		□ Billing Information □ Appointment Information □ Medical/Health Information
2.		□ Billing Information □ Appointment Information □ Medical/Health Information
3.		□ Billing Information □ Appointment Information □ Medical/Health Information
4.		□ Billing Information □ Appointment Information □ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

Signature of Patient/Responsible Party _____ Date _____

Name of Patient/Responsible Party (Print) _____ Relationship to Patient _____

Key Laser Institute
for Aesthetic Medicine

FINANCIAL POLICIES

Welcome to Key Laser Institute for Aesthetic Medicine. We are committed to providing our patients with the highest quality care for your skin's wellbeing. In order to serve you most effectively, we have outlined our patient's financial responsibilities and ask you to please review the following policies carefully. *Your signature is required to receive treatment.*

Fees

A New Patient Consultation is complementary. Any fees discussed with us before your consultation visit are considered estimates only. You will be given an individual treatment plan with fees, valid for a period of sixty (60) days. After 60 days, fees are subject to change. An additional consultation fee may be applied at Dr. Key's discretion for subsequent consultations.

ALL APPOINTMENTS REQUIRE A DEPOSIT to hold the agreed date and time. Please refer to the schedule below:

Payment Schedule Policy
50% of fee as deposit at the time of scheduling on all procedures and remaining 50% on scheduled procedure date

Special Pricing Offers

Special offers, promotions, and coupons are not combinable or valid with any other offer. ***Note:*** *Any broken package pricing reverts back to the individual price per unit/treatment.*

Insurance

Due to the fact that most treatments are considered elective and/or cosmetic in nature, we do not accept or bill insurance companies.

Cancellations, Rescheduling, & No-Shows

ANY provider appointment: In consideration of those patients waiting for appointments, we kindly ask that you always give us 48 hour notice of cancellation or need to reschedule an appointment. ***If you fail to adequately notify us of your need to reschedule or cancel less than 48 hours prior to your appointment date, you will be subject to a $100 cancellation fee. If you NO SHOW for your scheduled appointment without adequate notification, you will be subject to a 100% loss of your procedure deposit as resources have been carefully coordinated for your care.***

Appointments and any Procedures performed by Dr. Key*:*
Due to the additional planning and resources required for these appointments, please note the following cancellation policy:

- 72 hours prior to your scheduled procedure date will result in a 50% loss of your deposit
- 48 hours prior to your scheduled procedure date will result in a 100% loss of your deposit

Refunds, Cancellations, & Exchanges

Key Laser Institute does not offer refunds for treatment, services, or products (including prescription products). In the unlikely event you are unhappy with your Key Laser experience, you are encouraged to contact our patient coordinator to determine if a follow up appointment might relieve your concerns.

Payment Options

We accept cash, Visa, MasterCard, Discover, American Express, Care Credit®, credit/debit cards, personal/cashier checks, and business checks with valid identification. We will assess a $50.00 fee for any check returned to us for reason of non-sufficient funds (NSF).

We offer access to low- to no-interest patient financing options through CareCredit® Healthcare Finance. A CareCredit® card is designed specifically for your health and beauty needs. CareCredit® can help you move forward with getting the procedure you've always wanted and it's easy to apply. With convenient monthly payment options, no up-front costs and no prepayment penalties you can get your procedure sooner. You may contact CareCredit® directly at (800) 677-0718 or visit their website www.carecredit/cosmetic for more information. If you require further information, please contact Patient Services at 503-291-1953 or info@keylaserinstitute.com

I have read and understand the Financial Policies as set forth above.

Patient Signature: _____ Date: _____

Patient Print Name: _____

Witness: _____ Date: _____

Key Laser Institute
for Aesthetic Medicine

Out of Medicare HMO or Advantage Plan

Waiver Form

Patient Name: _____ Date of Birth: _____

Date of Service: _____ HIC# _____

Name of Medicare HMO, PSO,POS: _____

Your Signature below Signifies that you clearly understand that:

- Dr. Key is NOT a member of the Medicare HMO or Advantage Plan. Because the doctor is NOT on your plan, the expenses for today's visit will be your responsibility. This mean you will have to pay the doctor's charges in full before the end of today's visit.
- Certain Types of Medicare HMO's or Advantage Plans will not reimburse any money if the patient requests and seeks services from a physician that is NOT part of the Medicare HMO or Advantage Plan.
- Do not sign this form unless you absolutely understand the consequences of your visit, the charges you will have to pay out of pocket, and the fact that you may not receive any of the money back from your Medicare Plan.

I understand all of the above and still want to receive services from the non-participating physician today.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Key Laser Institute
for Aesthetic Medicine

HIPAA Acknowledgement & Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, consult with, coordinate among, and direct my treatment(s) and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with quality health care.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information are available, upon request, for my review.

I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Patient Name Date of Birth (MM/DD/YYYY)

_____ _____

Signed (Patient or Legal Representative for Patient) Date

_____

Legal Representative's Relationship to Patient