YOASH R. ENZER, MD, FACS
Cosmetic, Laser, & Oculofacial Plastic Surgery
ASHLEY L. WRIGHT, FNP
Aesthetic Nurse Practitioner
120 Dudley Street, Suite 104 | Providence, RI 02905
Tel (401) 274-4464 | Fax (401) 831-0710 | www.doctorenzer.com

Laser Hair Removal Patient Registration Form

PATIENT INFORMATION

Name: _____ Pharmacy: _____
Address: _____ Phone #: _____
City, State, Zip: _____ Marital Status: _____
Email Address: _____ Occupation: _____
Home Phone: _____ Medical Doctor: _____
Mobile Phone: _____ Phone #: _____
Work Phone: _____ Emergency Contact: _____
Date of Birth: _____ Relationship to Patient: _____
Social Security #: _____ Phone #: _____

HISTORY

1. Of what ancestry are you? (English, Russian, etc.): _____
2. For facial laser hair removal, have you ever had dermabrasion or a chemical peel? ..... Yes No
   If so, when, where, and by whom? _____
3. Are you currently using or have you ever used Retin-A? ..... Yes No
   If yes, when did you start? _____ When did you stop? _____
4. Are you currently using or have you ever used Accutane? ..... Yes No
   If yes, when did you start? _____ When did you stop? _____
5. Do you have any skin disorders? ..... Yes No
   If yes, please explain: _____
6. Do you have or have you ever had vitiligo (loss of skin pigment)? ..... Yes No
7. Are you a keloid former (extra large scars)? ..... Yes No
8. Do you ever get "herpes" skin eruptions or cold sores? ..... Yes No
9. Have you had laser hair removal in the past? ..... Yes No
   If yes, when did you start? _____ When did you stop? _____
10. Have you had electrolysis treatment for unwanted facial/body hair in the past? ..... Yes No
    If yes, when did you start? _____ When did you stop? _____
11. Have you had any problems with cosmetic treatments or surgery in the past? ..... Yes No
    If yes, when did you start? _____ When did you stop? _____

Name: _____

Date: _____

EXPECTATIONS

1. Please explain briefly where and what type of improvement you desire from laser hair removal:

SYSTEMIC REVIEW OF SYSTEMS

Place a check if you have any problems in the following areas, and give details on the back of the page.

- ☐ Constitutional (recent change in weight, energy level, temperature, etc.)
- ☐ Neurologic (brain, spinal cord, etc.)
- ☐ Head, ears, nose, throat, and sinuses
- ☐ Dermatologic (skin, hair, nails)
- ☐ Heart / Circulation (including blood vessels)
- ☐ Respiratory (lungs and breathing passages)
- ☐ Gastrointestinal (stomach, intestines, rectum)
- ☐ Genitourinary (genitals, kidneys, bladder, prostate)
- ☐ Hematologic (blood, clotting, and lymph glands)
- ☐ Endocrine (thyroid, diabetes, pancreas, etc)
- ☐ Rheumatologic (joints, autoimmune conditions)
- ☐ Allergy
- ☐ Psychiatric

SURGICAL HISTORY

List all surgeries and their dates (use the back of the page if necessary):

MEDICATIONS

List all your current prescription medications, including dosages (use the back of the page if necessary):

List all of your herbal and over-the-counter medications including dosages (use the back of the page if necessary):

ALLERGIES

Are you allergic to any medications, topical creams, or ointments? Yes No

If you answered **YES**, please give the name of the medication(s) and the reaction(s):

SKIN TYPE (Circle one from each column)

TYPE	SKIN TYPE	EYES	HAIR COLOR	REACTION TO FIRST SUN EXPOSURE
I	Very light	Blue	Red	Always burn, never tans
II	Light	Green	Blonde	Usually burn, tan with difficulty
III	Medium	Brown	Light brown	Sometimes mild burn, tan average
IV	Medium-dark	Black	Brown	Rarely burn, tan with ease
V	Dark brown			Rarely burn, tan very easily
VI	Black			Never burn, tan very easily

Clinician Signature: _____ Date: _____

Name: _____

Date: _____

PLEASE DO NOT WRITE BELOW THIS LINE

- ☐ Discussion completed regarding treatment options, expectations, risks, benefits, need for multiple treatments, and costs of laser hair removal
- ☐ Photographs taken of treatment area(s)
- ☐ Test spots performed
  Area: _____
  Fluence: _____
  Time: _____
  Response: _____

Skin Type: _____
Desired Treatment Area: _____

Notes: _____
_____
_____
_____
_____
_____

Clinician Signature: _____ Date: _____

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Patient Name: _____ **Date:** _____

Laser Hair Removal Pre- and Post-Treatment Instructions

BEFORE TREATMENT

1. Avoid the sun or tanning booths for 4 to 6 weeks before treatment. If you are going to be treating sun-exposed areas, apply sunblock (at least SPF 15) each morning for one month before treatment.

2. No bleaching, plucking, electrolysis or waxing of hairs in desired treatment area for six weeks.

3. If you have a history of herpes or cold sores, you may need antiviral medication. This medication should be started one day before laser treatment and continued for one week after treatment.

4. You may shave as often as desired.

5. **Carefully shave the treatment area the evening before your laser session.**

6. Arrive at our facility with the treatment area clean and free of makeup (if treating the face).

AFTER TREATMENT

1. There may be redness or swelling around the treated area. This may last for a few hours. The skin will be sensitive and feel similar to a sunburn. Treat the area gently by keeping the skin moist with either Aquaphor Healing Ointment or Aloe Vera Gel. If any blistering or scabbing develops, switch to Bacitracin Ointment and call the office.

2. Do not pick, rub, or scratch the area. Do not use any irritating substances on the treated area (i.e., Retin-A, glycolic acids, alpha-hydroxyacids, hair removal products, etc.) until the skin returns to normal.

3. If your face was treated, your skin will be extra-sensitive to heat. Keep away from the oven for 24 hours, and maintain a cool water temperature when taking a shower or bath.

4. If the treatment area will be exposed to the sun, apply sunblock (at least SPF 15) after the skin returns to normal. If the treated area seems to darken in color, call our office for bleaching cream.

5. If your face was treated, you may resume using makeup when the skin looks and feels back to normal.

6. Shedding of the hair follicle may or may not occur after 5 to 7 days.

7. The treated area should be ready for the next session in about 4 to 8 weeks.

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RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

All Patients: I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits or cosmetic services directly to Enzer & Associates, P.C. In the event you are required to proceed with any collection proceedings, **I agree to be responsible for all reasonable billing fees associated with the collection of my debt, including but not limited to 1.5% per month interest on the outstanding balance, plus attorney and/or collections fees (up to 33.3%)**. I agree that I will be responsible to pay Dr. Enzer for all services rendered, including those not covered, co-insurance balances, or denied for payment by my insurance company.
Medicare Patients: I request that payment of authorized Medicare benefits be made to Enzer & Associates, P.C. for any and all services furnished to me by said medical company. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature:	Date:

MISSED APPOINTMENT POLICY

Any appointment missed, cancelled, or rescheduled less than one (1) business day will be subject to the following fees. Appointment fees may be charged to a credit card. Should you wish to be billed, there will be an additional $25.00 fee from our billing company. All appointment fees must be paid in full prior to booking another appointment. **Leaving a message with our answering service the night before a scheduled appointment does not constitute one (1) business day notice.** I have read and agree to the terms of the appointment policy as stated above.

Dr. Enzer Missed Appointment Fees

Follow-up = $50.00 New Patient = $100.00
20 minute visit = $100.00 30+ minute visit = $150.00

Nurse Provider/Licensed Esthetician Fees

One half of treatment cost

Signature:	Date:

PATIENT PHOTOGRAPHY CONSENT

Enzer & Associates, P.C. may need to photograph you to document a medical condition, help with the diagnosis and/or treatment of a condition, submit for insurance billing requirements, and/or to help plan details of surgery. Photographs taken for these clinical reasons do not require your written permission. Your provider **does** need your written permission to use your photographs and details regarding medical services for the non-clinical reasons below. I hereby authorize Enzer & Associates, P.C. to photograph me for the following purposes:

	YES	NO
• For non-profit educational purposes outside Enzer & Associates, P.C., including teaching, lectures, medical publications, and presentations at professional conferences.	☐	☐
• To show current or future patients for the purpose of education and consultation. This may include, but is not limited to, printed patient education materials, social media, and/or website photos. **Our policy is to not post any patient photo to social media or our website Photo Gallery without your written approval.**	☐	☐

Enzer & Associates, P.C. will take all safeguards to protect my privacy and confidentiality in the use of these photographs. I consent to release any photo other than a full face frontal or side ("identifying") photo for the uses above without inspection or approval on my part of the finished product or specific use to which these photographs may be applied. I understand that although my name will not be used, it may be possible to identify me from a photo. Copies of the photos may be released to me if I ask for them. I may revoke my authorization at any time by written request.

Signature:	Date:

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HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

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, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have had the opportunity to read and understand your Notice of Privacy Practices regarding the uses and disclosures of my health information (a hard copy is not been enclosed; please ask receptionist if you wish to read the full text or receive a hard copy). 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 above to obtain a current copy of the Notice of Privacy Practices. I may also request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

☐ **I give my permission to be contacted by the following option(s):**

Home phone	Y	N
May we leave a message?	Y	N
Cell phone	Y	N
May we leave a message?	Y	N
Work phone	Y	N
May we leave a message?	Y	N
Mail	Y	N
Email	Y	N

☐ **I do NOT give my permission to be contacted by Enzer & Associates, PC.** I assume full financial responsibility for any and all missed appointments.

Permitted **Uses & Disclosures covered by HIPAA**: I hereby authorize Enzer & Associates, PC to disclose the following information to the named person(s) below:

___ Appointment date/times ___ Financial/Insurance ___ Medical (diagnosis/lab results) ___ Care Plan

Name: _____ Relationship: _____ Phone #: _____

Signature: Date:

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Directions/Policies

Directions to Southside Medical Center at 120 Dudley Street

Driving North on I-95: Take exit 18 for Thurbers Ave. Bear left onto Thurbers Ave. and turn right at the first light onto Eddy St. After .08 mi. turn left onto Dudley St. Free parking is in gated lot on left, directly across from Women & Infants Hospital. We are on the first floor in Suite 104.

Driving South on I-95: Take exit 19 for Eddy Street immediately after the split for I-195. Bear left on the exit towards Eddy St. Merge right onto Eddy St., and then turn right at the 1st light onto Dudley St. Continue 1/4 mi. on Dudley St. Free parking is in gated lot on left, directly across from Women & Infants Hospital. We are on the first floor in Suite 104.

Driving West on I-195: Merge onto I-95 South and take exit 1B (the first exit on the right) for Eddy St. At the light turn right onto Eddy St. At the next light take a left onto Dudley St. Continue Dudley St. for 1/4 mi. Free parking is in gated lot on left, directly across from Women & Infants Hospital. We are on the first floor in Suite 104.

Office Information & Policies

Office Hours: Our normal hours are 9:00 a.m. to 5:00 p.m. Monday through Friday. All emergencies calls are advised to call the office, your message will be relayed to Dr. Enzer or the covering provider immediately.

Appointments: All visits are scheduled by appointment. It is our policy to book ample time for your visit with our Providers, and we do our best to minimize patient waiting time. **If you should need to cancel or reschedule an appointment, we require minimum – 24 buisness hours advance notice**; otherwise you will be responsible for the visit fee and any other necessary billing or collection fees.

Registration Materials: In order to provide optimum care, our Providers request that you complete a medical history questionnaire prior to your visit. You may do this by downloading the registration forms from **www.doctorenzer.com**, requesting them by mail, or e-mail, or coming into the office 15 minutes early to fill out the forms. **Please bring a complete medication list (including over the counter/herbal supplements), photo ID, and insurance card(s) (if applicable)** to your visits. If you wear contact lenses, bring a case for them, as well as your glasses.

Insurance Coverage: For our medical patients, Dr. Enzer participates with the major area plans. Many plans require that the patient obtain permission to see Dr. Enzer for the initial and each follow-up visit. This is your responsibility. Please bring your insurance card (s) to the office so we can obtain accurate billing information. **If your insurance plan decides not to cover Dr. Enzer's services, you will be responsible for payment of the bill**. To contain costs, all payments are required at the time of service. We accept cash, checks, and all major credit cards. There is a billing fee for any unpaid balances. By minimizing our expenses, we help keep our fees competitive.

Reconstructive Procedures: Many reconstructive procedures will be covered by insurance plans. Our staff will help obtain this information in advance if possible. We make no representation or guarantee regarding what costs an insurance company will cover. All non-covered services will be the responsibility of the patient.

Cosmetic Surgery Costs: The cost of cosmetic surgery is not covered by insurance plans, and thus is the full responsibility of the patient. For more information regarding cosmetic surgery policies and fees, please go to the Office Policies section on our website at **www.doctorenzer.com**.