Finesse
Surgical Solutions

GENERAL • VASCULAR • COSMETIC
James W. Schlotter, MD, FACS
1347 Thorpe Lane, San Marcos, TX 78666
Office: (512) 395-8770 Fax: (512) 395-8772

Patient Name: *Last*_____ First _____ __Male __Female
Patients' Mailing Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____/_____/_____ Social Security Number: _____-____-_____
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed
Is the patient a full-time student? __ Yes __No If yes, where? _____
Patient's Employer: _____ Work Phone: _____
Home Telephone: _____ Cell Phone: _____
Email Address: _____ @ _____ . COM

Name of person who carries this insurance policy: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: ____/____/____ __ Male __Female SSN: _____-_____-_____
Employer: _____ Cell/Home Phone : _____
Relationship to Patient: ___ Self ___ Spouse ___ Child ___ Other
Name of Insurance: _____
Policy #: _____ Group #: _____

Emergency Contact: _____ Relationship: _____
Home/Cell Phone: _____ Work Phone: _____

Pharmacy Name: _____ Location of Pharmacy: _____

By signing below I attest that the above is correct and true. Also I have read and seen Finesse Surgical Solutions' HIPPA policy:

Signature: _____ Date: _____

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Pre and Post Laser Hair Treatment Instructions

Hair has three growing cycles which are all present at the same time. The length of hair growth cycles vary for different body parts.

Anagen Phase: Active phase of hair growth when laser hair removal is effective. Length of this stage is variable according to body part.

Catagen Phase: Last about 2-3 weeks. 3% of all hairs are in this phase.

Telogen Phase: Resting phase. Hair falls out in preparation for the development of new hair. Length of this stage is variable according to body part.

**Hair must be brown or black. Laser light is not absorbed by white, gray, red or light-blond hair.*

Prior to treatment:

1. No self-tanners or tanning for at least 2-4 weeks prior to treatment.
2. Removal all traces of make-up in the area before treatment.
3. Shave the area prior to treatment. One day of growth is good.
4. Do not wax or pluck prior to treatment.

Post treatment:

1. Erythema and perifollicular edema are common but not required for a successful treatment.
2. Hair may take up to 2-3 weeks to fall out.
3. Avoid heat for 24 hours – hot tubs, saunas, tanning etc…
4. If a blister or crusting develops, treat as a wound. Do not apply ice directly on the burn. Instead soak a washcloth in ice water and apply to the area.
5. Hair removal requires a series of treatments. The number of treatments depends on body location and type of hair. The average number of treatments is 5-8 sessions. It is important to keep a regular schedule with your treatments.
6. The average treatment interval is 6-12 weeks depending on the body part. We usually recommend treatment every 6 weeks.
   - The laser will only target hair in the “active” growth phase and there is no advantage to scheduling visits closer together.
   - The back, torso, legs may have a better outcome with longer treatment intervals (8 weeks apart).

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Fitzpatrick Skin Typing Questionnaire

One of the important parameters for the success of your treatment is the correct typing of your skin. Skin type is often categorized according to the Fitzpatrick skin type scale, which ranges from very fair (skin type I) to very dark (skin type VI).

The two main factors that influence skin type and the treatment program devised by your doctor are is the genetic disposition & the reaction to sun exposure and tanning habits

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) have a major impact on the evaluation of your skin color.

Please fill out this questionnaire, help us determine your skin type to treat you the right way. Thank You!

Genetic Disposition

Score	0	1	2	3	4	
What are the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black	_____
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/ Dark Blond	Dark Brown	Black	_____
What is the color of your skin (non-exposed areas)?	Reddish	Very Pale	Pale with Beige tint	Light Brown	Dark Brown	_____
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None	_____
				Total Score for Genetic Disposition		_____

Reaction to Sun Exposure

Score	0	1	2	3	4	
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rare burns	Never had burns	_____
To what degree do you turn brown?	**Hardly or not at all**	**Light color tan**	**Reasonable tan**	**Tan very easy**	**Turn dark brown quickly**	_____
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always	_____
How does your face react to the sun?	**Very sensitive**	**Sensitive**	**Normal**	**Very resistant**	**Never had a problem**	_____
				Total Score For Reaction to Sun Exposure		_____

Tanning Habits

Score	0	1	2	3	4	
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2 – 3 months ago	1 – 2 months ago	Less than a month ago	Less than 2 weeks ago	_____
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always	_____
				Total Score For Tanning Habits:		_____
				TOTAL SCORE FOR ALL SECTIONS		_____

Results

Skin Score	Skin Type	Skin Color	Sun Exposure Results In:
0 – 7	**I**	Northern European	Always burn / never tan
8 – 16	**II**	Northern European	Always burn / can lightly tan
17 – 25	**III**	Mediterranean	Can slightly burn / tans easily
26 – 30	**IV**	Asian / Middle Eastern	Never burn / always tan
Over 30	**V**	Indian	Always tan easily
Over 30	**VI**	African	Always tan easily

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Patient Consultation Form

FOR LASER HAIR REDUCTION

Date: _____

Name: _____ Age: _____ DOB: _____

Chief Complaint: _____

Past Medical History: _____

Surgical History: _____

Medications: _____

Allergies: _____

History	Yes	No	Date of Last Exposure
Waxing	Yes	No	_____
Plucking	Yes	No	_____
Electrolysis	Yes	No	_____
Shaving	Yes	No	_____
Accutane	Yes	No	_____
Cold Sores/Herpes	Yes	No	_____
Previous Laser Tx	Yes	No	_____
Keloids	Yes	No	_____
Perm lip/collagen	Yes	No	_____
Deodorant	Yes	No	_____

Benefits of the procedure was discussed	Yes	No
Contraindications were reviewed	Yes	No
Risk reviewed (pigment changes, bruising, swelling, infection, scarring, reoccurrence of hair, blistering)	Yes	No
Probability of success reviewed	Yes	No
Patient educated about anticipated consequences if treatment (tx) is not performed; and alternative procedures available	Yes	No
Verbal and written post-treatment instructions given to patient	Yes	No
Famvir Rx given	Yes	No
Next appointment scheduled Date: _____	Yes	No

Comments:

_____

_____

Signature of Patient: _____ Date: _____

Signature of Consultant: _____ Date: _____

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Patient Consent Form

FOR LASER HAIR REDUCTION

PATIENT NAME: _____

I hereby authorize and direct any associates or assistants of Dr. Schlotter to perform laser assisted hair removal on me. I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I also understand some people may not experience complete hair loss even with multiple laser procedures.

The following points have been discussed with me:

- The potential benefits of the proposed procedure. **Initial** _____
- The possible alternative procedures. _____
- The probability of success. _____
- The reasonably anticipated consequences if the procedure is not performed. _____
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including, but not limited to, infection, scarring, crusting, re-growth of hair, and/or blistering. _____
- Post treatment instructions. _____

I am aware of the following possible experiences/risks with Laser Hair Reduction:

- **DISCOMFORT** Some discomfort may be experienced during laser treatment. _____
- **WOUND HEALING** Laser Surgery can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients. _____
- **BRUISING/SWELLING/INFECTION** With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility although rare, whenever a skin procedure is performed. _____
- **PIGMENT CHANGES** (Skin Color) During the healing process, there is a slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent. _____
- **SCARRING** Scarring is a rare occurrence, but it is a possibility when the skin's surface is disrupted. To minimize the changes of scarring, it is **IMPORTANT** that you follow all post-treatment instructions carefully. _____
- **EYE EXPOSURE** Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure. _____

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NONREFUNDABLE. BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER HAIR REMOVAL TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

_____	_____	_____
Signature-Patient or Guardian	Print Name/Relationship	Date
_____	_____	_____
Signature-Witness	Print Name	Date

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Financial Policies

Our office has contracts with most (local) insurance companies. We will be glad to file your claim minus any deductibles owed and/or copay. We will file your claim to your primary and secondary carriers but not a third policy. Our office does **not** file any claims for **Worker's Compensation or Motor Vehicle Accidents**. You must pay for any charges related to these two carriers. We will provide you with an itemized statement to present to your insurance company so that you may be reimbursed.

Our office accepts assignment on Medicare, Medicaid, and Tricare claims. This means that we will file your claim for all covered services and they will reimburse us directly. Every Medicare patient has a deductible each year. Medicare patients pay 20% of the allowed charges ***after*** any deductible has been met at the time of service. Our office will file a secondary claim once. **If your secondary insurance does not respond to the claim within 60 days we will forward the claim to you for payment.**

If your insurance requires a predetermination prior to any procedure our office will do the necessary paper work to obtain their approval. Prior to your procedure an attempt will be made to verify your benefits and ***estimate* the dollar amount that you will need to bring on the day of your surgery/procedure. We will file the claim to your insurance company. We will provide them with any medical documentation that they may request so that your claim will be paid. By law insurance carriers have 45 days to process clean claims. Occasionally we encounter problems with insurance companies that delay payment on our patient's claims. If this happens to your claim, we ask that you contact your carrier and find out what information they need and inform our office. **If after 90 days the claim has not been paid we will forward a bill to you for payment.** _____ **Initial**

Since many of our services are done in "staged procedures" (over multiple dates), we will send refunds for overpayment(s) to patients once all treatment is completed and all claims have been paid by insurance companies. _____**Initial**

If you do not have insurance we require payment in full at the time of service. We except cash, check, Care Credit, Master Card, Visa, and Discover Card. _____**Initial**

Due to the large block of time that most of the vein procedures require, our clinic requires a $300.00 deposit when scheduling a surgery. This deposit will be applied towards the cost of your procedure. **We require 72 (business days) hour notice of cancellation to receive a deposit refund. _____**Initial**

Failure to keep office appointments charges: 1st $25, 2nd $50 and 3rd $100 Cosmetic Appointments require $100 to reserve initial consultation. The patient will forfeit the $100 if they fail to cancel appointment or reschedule 24 (business) hours prior to scheduled time. _____**Initial**

I hereby assign medical and or surgical benefits, to include major medical benefits, to which I am entitled, (Medicare, Medicaid, HMO, PPO, Private Insurance) payable to James W. Schlotter, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize said assignee to release all medical information necessary to secure the payment. **I have read, understand and agree to the above policy.**

Signature of insured/patient:_____ **Date:** _____

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PF-100

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can have access to this information. Please review it carefully.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Heath care operations. Your health information may be used as necessary to support the day-to-day activities and management of **James W. Schlotter, M.D, F.A.C.S**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information. Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights. You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information (a charge for copies will apply).
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

The practice of James W. Schlotter, M.D., F.A.C.S. duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also required to abide by the privacy polices and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy polices and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Receptionist or Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints. If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
James W. Schlotter, M.D.
1347 Thorpe Lane
San Marcos, TX 78666

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person. The name and address of the person you may contact for further information concerning our privacy practices is: **Michelle Schlotter**

This notice is effective on or after April 3, 2003.

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Office Policy for Failure to Cancel Appointments

Office visits and surgeries need to be cancelled 48 (business) hours prior to scheduled appointment. Failure to speak directly with our office staff to reschedule or cancel will result in a fee of:

$25 for 1st failure to cancel

$50 for 2nd failure to cancel

$100 for 3rd failure to cancel

The above fee will need to be paid when rescheduling your appointment.

While most of our patients are very good at keeping their scheduled appointments we do have patients who fail to notify us that they will not be coming in. Many of our procedures and appointments are anywhere from 45 minutes to 2 hours long. When a patient fails to cancel at least 48 hours prior to their appointment it leaves a large block of empty time that could have been given to another patient. This causes financial and schedule disruptions to our practice.

We appreciate your understanding while we implement this policy into our practice.