MELISSA DEAN, MD

Dean Wellness & BODY AESTHETICS

1345 36TH ST, SUITE B, VERO BEACH, FL, 32960 P.772.567.1500 F.772.567.1505 deanwellnessinstitute.com

DATE: _____

PATIENT NAME: _____ BIRTHDATE: _____

PARENT/GUARDIAN: _____EMAIL: _____

PRIMARY STREET ADDRESS: _____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL PHONE:_____
ALTERNATE WORK/FAX NUMBER:_____

SECONDARY ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

DRIVER'S LICENSE #:_____ STATE:_____

SEX: M F

MARITAL STATUS: M S D W SOCIAL SECURITY NUMBER: _____-_____-_____

EMPLOYED? YES NO (IF YES CONTINUE) EMPLOYER:_____

WORK PHONE:_____ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

SPOUSE/SIGNIFICANT OTHER:_____BIRTHDATE:_____

ADDRESS (IF DIFFERENT):_____

CITY:_____STATE:_____ZIP:_____

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU THAT WE MAY CONTACT IN THE EVENT OF AN EMERGENCY.

NAME: _____RELATIONSHIP: _____

PHONE 1:_____ PHONE 2:_____

STREET
ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

How did you hear about us? _____

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name_____Birthdate:_____

Information to Be Released -- Covering the Periods of Health Care

From (date) _____to (date) _____
From (date) _____ to (date) _____

Please check type of information to be released:

__ Pertinent Documentation __ Operative Report __ Lab Results __ Complete health record
__ History and physical __ Consultation reports __ Progress notes __ EKG
__ Discharge Summary __ X-ray reports __ X-ray films/images __ EEG
Other:_____

Purpose of Request:

___ Treatment or consultation ___ At the request of the patient ___ Billing or claims payment
Other, (specify)

_____

I, the undersigned authorize and request Dean Wellness Institute TO ___Release information to OR ___ Obtain information from:

Name: _____
Address: _____
_____

- Medical record are to include any and all Federal and State protected information without limitation to include diagnosis, treatment and/or examination related to mental health related care, drug and/or alcohol abuse, HIV testing/AIDS, and sexually transmitted diseases.
- By signing this release, you understand that this authorization will remain in effect for 180 days or until revoked in writing (whichever transpires first). Dean Wellness Institute is authorized to use outside vendors for the purpose of copying and providing the information requested.
- I understand that the state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorization, but that Dean Wellness Institute cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition.
- I understand I have the right to inspect and obtain a copy of any information disclosed.
- I hereby release Dean Wellness Institute and its employees from any and all liability that may arise from the release of information as I have directed
- I understand that if I have requested duplication of records within a one year time period (of the same of similar records), I may be charged a fee of up to $1.00 per page for every page copied. This fee may be waived for copies provided to a health care provider, insurance company or other specific organizations for treatment, billing or operations purposes.

_____ _____

Signature of Patient or Legal Representative Date

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_____ _____

Printed Name of Patient or Legal Representative Relationship

AUTHORIZATION FOR RELEASE OF INFORMATION TO ANOTHER PERSON

PATIENT NAME:_____DATE:_____

PLEASE LIST THE FAMILY MEMBERS, SPOUSE OR OTHER PERSON(S), IF ANY, TO WHOM WE MAY RELEASE YOUR CONFIDENTIAL MEDICAL INFORMATION.

IF AUTHORIZED, DEAN WELLNESS INSTITUTE MAY RELEASE YOUR INFORMATION TO ANY AUTHORIZED PERSON(S) VIA TELEPHONE OR IN PERSON REGARDING YOUR GENERAL MEDICAL CONDTION AND/OR YOUR DIAGNOSIS (INCLUDING TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS).

AUTHORIZED PERSON'S NAME:_____RELATIONSHIP:_____

AUTHORIZED PERSON'S NAME:_____RELATIONSHIP:_____

AUTHORIZED PERSON'S NAME:_____RELATIONSHIP:_____

☐ I DO NOT AUTHORIZE DEAN WELLNESS INSTITUTE TO RELEASE MY INFORMATION TO ANYONE

NOTICE: THIS AUTHORIZTION IS FOR FULL DISCLOSURE OF PERTINENT RECORDS. IF THERE IS ANY INFORMATION THAT YOU DO NOT WANT DISCLOSED TO THE NAMED PARTY, PLEASE INDAICATE BELOW WHAT PORTION(S) OF RECORD YOU WISH TO BE EXCLUDED.

EXCLUSIONS:_____

_____

_____

I HEAREBY GRANT DEAN WELLNESS INSTITUTE THE APPROVAL TO DISCUSS MY MEDICAL HISTORY AS OUTLINED ABOVE. ANY EXCULSIONS HAVE BEEN NOTED.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL RESCINDED BY MYSELF IN WRITING.

PATIENT (OR LEGAL REPRESENTATIVE) SIGNATURE:_____DATE:_____

WITNESS NAME:_____WITNESS SIGNATURE:_____

THESE RECORDS ARE CONFIDENTIAL AND NOT FOR RE-RELEASE BY ANY FACILITY OTHER THAN DEAN WELLNESS INSTITUTE.

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YOUR CONFIDENTIAL MEDICAL HISTORY

PATIENT NAME: _____ DOB: _____

CHIEF COMPLAINT:
LOCAL PHARMACY:
MAIL ORDER PHARMACY:

CHRONIC MEDICAL CONDITIONS:	**DATE DIAGNOSED:**	**PHYSICIAN:**

PREVIOUS PROCEDURES AND/OR TESTS	DATE:
CHEST X-RAY?	
EKG?	
BLOOD WORK?	
PNEUMONIA VACCINE?	
FLU SHOT?	
TETANUS SHOT?	

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EYE EXAM?	
ADDITIONAL PERTINENT INFORMATION:	

PREVIOUS PHYSICIANS:	**CITY AND STATE:**

PAST SURGERIES/HOPITALIZATIONS:	**DATE/S:**	**PHYSICIAN:**

FAMILY MEDICAL HISTORY:	**LIVING:**	**CHRONIC ILLNESS OR CAUSE OF DEATH:**
MOTHER:		
FATHER:		
BROTHER/S:		
SISTER/S:		
GRANDPARENTS:		

SOCIAL HISTORY:

Do you have a Living Will, Advanced Directive, Power of Attorney or Medical Surrogate? **YES NO**
(If yes please provide a copy to keep in your file)

Do you smoke? **YES NO** _____ packs or cigarettes per day; How long? _____

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Do you drink caffeinated beverages? **YES** **NO** Type of beverage_____How many per day/week? _____

Do you drink alcoholic beverages? **YES** **NO** Type of beverage_____How many per day/week? _____

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING PRESCRIPTIONS, OVER THE COUNTER DRUGS, VITAMINS AND NATURAL SUPPLEMENTS:	**STRENGTH AND HOW OFTEN:**

ALLERGIES:	**TYPE OF REACTION:**

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_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

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APPOINTMENT CANCELLATION POLICY

At Dean Wellness Institute, our goal is to make our medical practice accessible to as many individuals and families as possible. Because the specialties of the services we offer are in high demand, we maintain a full schedule. This includes patients who are waiting on our "ASAP list". Our careful scheduling allows us to provide each patient with the individual attention necessary for the highest quality medical care.

When someone cancels only shortly before an appointment, we miss the opportunity to treat another person in need of care. We appreciate your courtesy in calling us at **least 24 business hours** prior to your scheduled appointment. Please call during business hours (Mon –Thurs 9:00 AM – 5:00PM and Fri 9:00 AM – 3:00 PM).

Because many patient's consultations require at least one hour of the Doctor's time, these appointments are scheduled weeks ahead of time. With our busy practice, the **24 HOUR NOTICE** will give us a chance to give the time allotted to you to another person.

Be advised, that you will be charged a fee of **$50.00** for missed visits that are not cancelled within this time frame.

EXCEPTION: This policy does not apply to IV appointments. ALL IV patients are required to call no later than 7:00 AM on the morning of the appointment if unable to keep the appointment. If the IV is made for you, you will be charged for the IV IN FULL.

I have read and understand the 24 HOUR CANCELLATION POLICY and hereby sign my acknowledgement below.

_____ _____

Name of Patient or Responsible Party Date

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CLINIC INFORMATION & POLICIES

"Alternative Medicine", "Complementary Medicine", "Complementary Alternative Medicine (CAM)", "Integrative Medicine", "Functional Medicine", "Holistic Medicine", "Non-traditional Medicine", are all names that have been used to describe this type of healing care. The general attempt is to express the nature of the type of healing care we provide. This is achieved by encouraging a broader view of the nature of the problem to extend beyond the physical to the mental and spiritual as well.

PLEASE READ THE FOLLOWING CLINIC POLICIES:

PAYMENT: Payment is due for services at the time they are rendered. Cash, personal check, VISA, MASTERCARD or DISCOVER are accepted. For payment delayed more than 14 days from the date of service, you will receive a bill and will be charged a "billing fee" of $50 in addition to the outstanding balance and any accrued interest. Interest will be calculated at the rate of 3% monthly. Any check returned to us for non-sufficient funds (NSF) will accrue an additional $50 fee. This will be added to the unpaid balance plus any accrued interest as stated above.

NON-COVERED SERVICES: Some of the services provided by this clinic are considered "non-covered services" or "investigational services" by your insurance company. Be aware of this and read your own policy for details or call your own insurance company in advance for clarification.

MEDICARE/MEDICAID: One or more physicians at Dean Wellness Institute **does NOT participate with MEDICARE or MEDICAID.** If you choose to see that physician, full payment is due at the time of your visit, and you are not eligible for reimbursement.

PRESCRIPTION REFILLS: DO NOT wait until the last minute to call in your prescription refill requests. **We require 72 BUSINESS HOURS** for requests to call in a prescription. Your PHARMACY may require ANOTHER 24 hours (48 hours for custom) to fill it.

TERMINATION OF RELATIONSHIP: Repeated non-compliance with therapy, missed appointments or failure to cancel two appointments consecutively without proper prior notice will result in our practice terminating our future care with you.

ARBITRATION: We are careful to explain our clinic policies, billing practices, our treatment philosophy, and our treatment plans. Disputes can arise in ANY relationship, including this one between us. Our agreement to provide medical services to you IS CONDITIONED UPON your agreement that ANY DISPUTE arising between us for which legal remedy may exist shall be pursued through binding arbitration pursuant to RCW 7.04.010 et seq.

A copy of this document is as valid as the original.

The above two pages is a notification of clinic policies. Please sign below that you understand and agree to the above.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE Date

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MEDICARE PART B PRIVATE CONTRACT

_____, a patient and/or Medicare Part B beneficiary ("Beneficiary"), and Melissa A. Dean, M.D., a physician licensed to practice medicine in Florida ("Physician"), enter into this agreement for the provision of medical items and/or services in accordance with the provisions of Section 4507 of the Balanced Budget Act of 1997. Wherefore, in exchange for consideration, the receipt and sufficiency of which the Parties hereby acknowledge, Beneficiary and Physician agree as follows:

1. Physician has not been excluded from Medicare under §§ 1128, 1156 or 1892 or any other section of the Social Security Act.
2. Beneficiary, or Beneficiary's legal representative, accepts full responsibility for payment of charges for all services furnished by Physician.
3. Beneficiary, or Beneficiary's legal representative, understands that Medicare limits do not apply to what Physician may charge for items or Services furnished by Physician.
4. Beneficiary, or Beneficiary's legal representative, agrees not to submit a claim to Medicare or to ask Physician to submit a claim to Medicare.
5. Beneficiary, or Beneficiary's legal representative, understands that Medicare payment will not be made for any items or services furnished by Physician that would otherwise have been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
6. Beneficiary, or Beneficiary's legal representative, enters into this contract with the knowledge that Beneficiary has the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
7. The expected or known effective date and expected or known expiration date of the opt-out period are February 14, 2015 (effective date) and February 14, 2027 (expiration date).
8. Beneficiary, or Beneficiary's legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
9. This contract cannot be entered into by Beneficiary, or Beneficiary's legal representative, during a time when Beneficiary requires emergency care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.)
10. Beneficiary, or Beneficiary's legal representative, will receive or has received a copy of this contract before items or services are furnished to Beneficiary under the terms of this contract.
11. Physician will retain the original contract for the duration of the opt-out period.
12. Physician will supply the Centers for Medicare and Medicare Services with a copy of this contract upon request.
13. Physician understands that the current private contract remains in effect for the duration of the opt-out period. If Physician again opts-out of Medicare, Physician will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Signature of Beneficiary or Legal Representative: _____
Date: _____ Time: _____
If Legal Representative, Print Name and Relationship: _____
Signature of Physician: _____ Date: _____ Time: _____

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Signature of Witness: _____ Date: _____ Time: _____

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Cosmetic Interest Questionnaire (Optional)

Name:_____Date: _____

What are your areas of concern? (Mark all that apply)

- € Frown lines
- € Lines around nose and mouth
- € Crow's feet
- € Facial hair
- € Acne
- € Freckles
- € Rosacea
- € Fine lines and wrinkles
- € Rough skin texture
- € Sagging/loose skin
- € Hyperpigmentation/discoloration
- € Dark circles under eyes
- € Dry skin
- € Surgical Scars
- € Stretch marks
- € Urinary Incontinence
- € Vaginal laxity
- € Erectile Dysfunction
- € Scarring (Location: _____)
- € Other: _____

When you look at your face in a mirror, do you feel that you look younger than, the same as, or older than your actual age?

€ Younger € True to age € Older

When looking in the mirror, how concerned are you regarding the appearance of your wrinkles?

€ Not Concerned € Somewhat Concerned € Very Concerned

Are you interested in learning more about the following?

- € Botox/Dysport
- € Juvederm/Restylane

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- € Vampire Facelift
- € Vampire Breastlift
- € Microneedling
- € Obagi Medical products
- € Retin-A
- € Acne Treatment
- € Hair removal
- € Chemical Peels
- € ThermiSmooth
- € Vaginal Rejuvenation
  - O-Shot
  - ThermiVA
- € Erectile Dysfunction
  - P-Shot

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Cosmetic Intake (Continued)

Name: _____Date: _____

Please use the following diagrams to elaborate on your areas of concerns: