

### MY SPECIALTY

I am a board certified dermatologist - a specialist trained to diagnose and treat disorders of the skin, hair and nails. I perform general skin, cosmetic surgery and laser surgery. My staff provides cosmetic treatments such as non-surgical body sculpting (endermologie), various facial peels and laser hair removal.

I am highly skilled in the non-surgical injection and laser treatment of varicose and spider veins.

### INITIAL VISIT

The initial fee ranges from \$75.00 - \$250.00 and return visits range from \$55.00 - \$200.00. Payment is expected at the time service is rendered, unless your insurance policy covers office visits. Visa and MasterCard are accepted.

### OFFICE HOURS

Office hours are Monday through Friday, 9:00 - 5:00. My patients are seen by appointment only.

### INSURANCE

It is my policy to process insurance forms for any procedures that are performed. I do not, however, participate in claims for Workmen's Compensation. As a participating physician, I accept, as payment in full, the amount that your insurance company decides is a reasonable and customary payment with the exception of co-payments and deductibles which are your responsibility. **All insurances requiring prior authorization or referrals must be obtained by the patient prior to every appointment.**

### SURGICAL FEES

Please be aware that most insurance companies, including Medicare, pay only office visit fees for the initial consultation. Surgical procedures are not covered for the initial visit and are probably best performed at a later date. In addition, most companies pay full fees for only one surgical procedure per visit. Multiple procedures may require multiple visits.

### PLEASE HELP US

Please notify us of any changes in your address, telephone number or your insurance plan. If you have any questions, please feel free to discuss them with my staff or myself.

### THANK YOU

I look forward to meeting you.

Sincerely,

*Stanley S. Roland, D.O.*

Stanley S. Roland, D.O.

#### Gentle, effective care

- Simple walk in, walk out procedures
- Removal of unsightly varicose & spider veins
- Body contouring
- Skin rejuvenation
- Skin cancer testing & treatment

#### Convenient, affordable care

- Insurance accepted & filed
- Credit cards welcome
- Evening hours
- Payment plans available

610 North Main Street  
Lapeer, Michigan 48446  
**(810) 667-9000**

**PATIENT INFORMATION**

(Please Print)

Today's Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_  
 Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

**RESPONSIBLE PARTY (if different from patient)**

Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ SS# \_\_\_\_\_  
 Date of Birth \_\_\_/\_\_\_/\_\_\_ Sex \_\_\_\_\_

**INSURANCE INFORMATION (Please present insurance card at time of check in)**

<b>Primary</b> Insurance Name _____	<b>Secondary</b> Insurance Name _____
Name of Insured _____	Name of Insured _____
Date of Birth of Insured ___/___/___	Date of Birth of Insured ___/___/___
Insured's SS# _____	Insured's SS# _____
Group # _____	Group # _____
Relationship of patient to the Insured _____	Relationship of patient to the Insured _____
Employer Name _____	Employer Name _____
Employer Phone _____	Employer Phone _____

Other family members that are patients \_\_\_\_\_  
 Pharmacy of choice \_\_\_\_\_ Phone \_\_\_\_\_  
 In case of Emergency, who should be notified? \_\_\_\_\_ Phone \_\_\_\_\_  
 Referred by \_\_\_\_\_  
 Primary Care Physician \_\_\_\_\_

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature/Parent or Guardian if Minor \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

I understand and agree that, (regardless of my insurance status) I AM ULTIMATELY RESPONSIBLE for the balance on my account for any professional services rendered. I have read and filled out all of the health questions and insurance information to the best of my ability. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status of insurance status as indicated in the above information.

**MONTHLY SERVICE CHARGES OF 1.5% (TIME/PRICE DIFFERENTIAL ARE ASSESSED ON UNPAID BALANCES). UNLESS CANCELLED 24 HOURS IN ADVANCE, \$55.00 WILL BE CHARGED FOR MISSED APPOINTMENTS. ALSO FOR NO SHOW SURGERY APPOINTMENTS \$150.00 PER EACH 30 MINUTES OF MISSED APPOINTMENT TIME WILL BE CHARGED.**

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OF GUARDIAN (IF MINOR)

\_\_\_\_\_  
DATE

**CURRENT MEDICAL INFORMATION**

What type of problem will you be consulting Dr. Roland for today? \_\_\_\_\_

How long has the problem existed? \_\_\_\_\_

Please state the location of the problem: \_\_\_\_\_

Is there anything else you would like to tell us about why you are here today? \_\_\_\_\_

**MEDICAL INFORMATION**

Are you allergic to any medications? Yes \_\_\_ No \_\_\_

If yes, please list: \_\_\_\_\_

Please list any medications you are currently taking, including birth control and vitamins:

Medication \_\_\_\_\_ How Long? \_\_\_\_\_

Medication \_\_\_\_\_ How Long? \_\_\_\_\_

Medication \_\_\_\_\_ How Long? \_\_\_\_\_

Medication \_\_\_\_\_ How Long? \_\_\_\_\_

Medication \_\_\_\_\_ How Long? \_\_\_\_\_

**PREVIOUS HOSPITAL ADMISSIONS**

<u>Procedure</u>	<u>Year</u>
_____	_____
_____	_____
_____	_____
_____	_____

**ARE YOU INTERESTED IN RECEIVING INFORMATION ABOUT:**

- Botox
- Laser Hair Removal
- Removal of varicose and spider veins
- Elite Skin Care products
- Cellulite treatment, Endermology
- Large Pores
- Brown Spots
- Flushing
- Restylane
- Collagen
- Lipo Therapy / Mesotherapy
- Massage therapy
- Treatment of wrinkles and aging skin
- Waxing
- Would you like to be on our mailing list? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

*Please visit our website at: [www.stanleysroland-do.com](http://www.stanleysroland-do.com)*

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE CHECK THOSE THAT APPLY:**

**CARDIO-RESPIRATORY SYSTEM**

- History of TB or exposure to TB?
- Chest pain or tightness in chest?
- Shortness of breath with exertion?
- High blood pressure?
- Shortness of breath when lying down?
- Heart attacks?
- Asthma?
- Emphysema?
- Wheezing?
- Night sweats?
- Swollen ankles?
- Varicose vein problems?
- Pain in legs or back when walking?
- Cough?

**NEUROPSYCHIATRIC**

- Coordination?
- Slurred or difficult speech?
- Numbness or tingling?
- A tremor in your hands?
- Hallucinations?
- Depression?
- Your memory?
- Your balance?
- Seizures?
- Have you ever had psychiatric help?
- Have you ever been unconscious?

**GASTRO-INTESTINAL SYSTEM**

- Yellow jaundice?
- Abdominal pain or indigestion?
- Eating fatty foods?
- Constipation or diarrhea?
- Hemorrhoids?
- Your gallbladder?
- Black or bloody bowel movements?
- Painful bowel movements?

**NEUROMUSCULAR SYSTEM**

- Pain in back or joints?
- Pain in muscles?
- Arthritis or gout?

**GENITO-URINARY SYSTEM**

- Burning pain when passing urine?
- Starting flow of urine?
- Emptying bladder?
- Holding urine?
- Frequency of urination?
- Night time urination?
- Pain over kidneys or bladder?
- Different color of urine?
- A hernia?

**ENDOCRINE**

- Diabetes?
- Thyroid gland?
- Increased thirst or appetite?
- Sensitivity to cold?
- Extreme nervousness?
- Increased sweating?
- Attacks of weakness?

**FAMILY HISTORY**

- Diabetes?
- High blood pressure?
- Heart trouble?
- Early death?
- Cancer?

**WOMEN ONLY**

- Abnormal menstrual periods?
- Breast discharge?
- Vaginal bleeding between periods?
- Excessive body hair?
- Could you presently be pregnant?

**HEMATOLOGY**

- Bleeding disorder?
- Frequent nose bleeds?
- Easy bruising?
- Bleeding long after a cut?
- Have you ever had a blood transfusion?
- Do you heal with normal scars?
- A reaction or allergies to local anesthetics?
- Have you been tested for AIDS or Hepatitis?

Do we have permission to:

- Leave a message on your answering machine at home?
- Leave a message at your place of employment?
- Discuss your medical condition with any member of your household?
- Discuss your financial information with any member of your household?

YES      NO

_____	_____
_____	_____
_____	_____
_____	_____

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Signature of Patient or Responsible Party if a Minor

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Date

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Please Print Name of Patient

**STANLEY S. ROLAND, D.O., P.C.**  
**The Dermatology and Cosmetic Care Center**

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610 North Main  
Lapeer, Michigan 48446  
810-667-9000

174 South Main  
Romeo, Michigan 48065  
586-752-4100

**PATIENT FINANCIAL POLICY**

- In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our practice administrator. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.
- Your insurance policy is a contract between you and your insurance company; the doctor is not involved.
- It is your responsibility to get all referrals if your insurance requires them. It is between you, your primary care physician and the insurance company. You will be financially responsible if no authorization is received. Your primary care physician is responsible for sending the referral to the insurance company. We have no responsibility in getting the referrals or authorizing treatment.
- As a courtesy, we will file your insurance claims for you if you assign the benefits to the doctor. In other words you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 90 days, we will have to look to you for payment.
- We have made prior arrangement with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. We will collect the co-payment when you are here for your appointment.
- If you have insurance coverage with a plan that we do not have a prior agreement we will also bill that plan, although you may have a higher co-payment or deductible for which you will be responsible.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- For all services rendered to minor patients, we will look to the adult accompanying the patient for payment. Whoever brings the patient in and signs the paperwork is financially responsible for payment.
- In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment.
- If a balance remains outstanding for longer than 60 days and no payment arrangements have been made with the billing department, that account will be turned over to a collection agency.
- I have read and understand that financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

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Signature Patient or Responsible Party if a Minor

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Date

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Please Print the Name of the Patient