Finesse
Surgical Solutions
GENERAL • VASCULAR • COSMETIC
James W. Schlotter, MD, FACS

(512) 395-8770 Office
(512) 395-8772 FAX

Patient Name: _____ Male or Female

Patients' Mailing Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Soc. Sec # _____-_____-_____

Martial Status: Single Married Divorced Widow (**Please circle**)

Is patient a full time student? Yes or 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: _____

DOB: _____/_____/_____ Male or Female Soc. Sec # _____-_____-_____

Employer: _____Work Phone: _____

Relationship to patient: Self Spouse Child Other (**Please circle one**)

Name of Insurance: _____

Policy #: _____ Group #: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Signature: _____ Date:_____

Pharmacy Name: _____ Location of Pharmacy: _____

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Financial Policy

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**

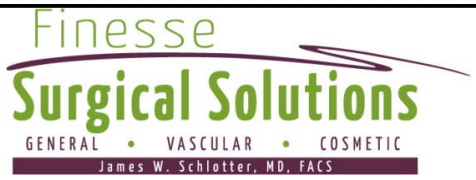
Due to the large block of time that most of the vein procedures require, our clinic requires a $300.00 deposit when scheduling a surgery. This deposit will be applied towards the cost of your procedure. **We require 72 (business days) hour notice of cancellation to receive a deposit refund. _____ Initial

Failure to keep office appointments charges: 1st $25, 2nd $50 and 3rd $100 _____ 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: _____

James W. Schlotter, M. D., F.A.C.S.



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.** 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. 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:

Office Manager
James W. Schlotter, M.D.
1347 Thorpe Lane
San Marcos, TX 78666
(512) 395-8770

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

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Consent for Laser Genesis for Onychomycosis

I hereby authorize **James W. Schlotter, MD** or his staff, under **Dr.Schlotter's** supervision to treat my **onychomycosis**, or **nail fungus** with the Cutera Cool Glide Genesis System. I understand that multiple treatments may be required and it is possible the result will be minimal or may not help at all.

The procedure may result in the following adverse experiences or risks:

- MILD DISCOMFORT – A slight and uncomfortable warming sensation may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising of the treated area.
- SKIN COLOR CHANGES – During the healing process, there is a possibility that the treated area may become either lighter (hypo pigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- BURNS and INFECTION – Treatment can result in burning and blistering of the treated areas, and subsequent infection. If signs of infection develop, such as pain or redness at the treated site, immediately call our office at **512-395-8770**.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- EYE EXPOSURE – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the Laser Genesis treatment of nail fungus, including the possibility that the procedure may not work for me.
- Alternative treatments such as topical or oral medications or even surgery
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep **Dr. Schlotter** and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby **do___do not___**authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FORM FOR LASER GENESIS TREATMENT, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

_____	_____	_____
Signature of Patient	**Printed Name**	**Date**
_____	_____	_____
Signature of Witness	**Printed Name**	**Date**

James W. Schlotter, M.D., F.A.C.S.
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Recommended Pre & Post Care for Onychomycosis Treatments
For best results please follow these instructions

Before your treatment:

- Remove nail polish
- Ensure nails are trimmed & cleaned thoroughly with a nail brush
- Spay all shoes with any-fungal spray or disinfectant (Lysol). Continue weekly for at least 4 weeks.
- Do not apply topical or antifungal cream or powder for 2 days prior to treatment

After your treatment:

- To help prevent re-infection:
  - Wear clean socks/shoes after treatment
  - Wash sheets, disinfect shower/bath and vacuum carpets day of treatment
  - Apply anti-fungal cream or spray to entire sole of foot, in between and on top of every toe twice a day for approximately 2 weeks(severe athlete's foot infections may require longer)
  - Apply anti-fungal powder or spray to all shoes at least once a week for at least 4 weeks
  - Do not walk barefoot in public places (pool, gym, etc.)
  - Keep nails trimmed and cleaned (disinfect instruments after each use)

- Nail polish may be applied 24 hours after treatment
- Toenails may take 9-12 months & fingernails may take 6-9 months to grow out
  - Severely infected nails may take longer
- Notify clinic of any concerns: **512-395-8770**
- Additional instructions:

_____
_____