

ADVANCED LASER &  
SKIN CARE CENTER  
MEDICAL GROUP, INC.



Michael J. Tomcik, M.D., P.C.  
Helen Petros, NP, PA-C

Board Certified Dermatologist

**NEW PATIENT INFORMATION**

**Welcome** – Thank for coming to see us. This information serves to introduce you to our office and our policies. We are committed to your treatment being successful.

**Office Specialty** – Dr. Tomcik, a Board Certified Dermatologist and Helen Petros, NP, PA-C are trained to diagnose and treat all manner of skin, hair, and nail diseases. A Dermatologist is a physician trained in the evaluation, treatment and/or removal of any growth on or under the skin. Cosmetic Dermatologists specialize in Laser Skin Rejuvenation, Tumescant Liposuction, Botox, Dysport, Derma Fillers and Foto Facial (IPL).

**Registration** – All patients must complete and sign our Patient Information Sheets prior to beginning treatment. It is important that we have all of the information and that it is kept current. Please notify us of any changes as they occur.

**Appointments** – Your appointment time is reserved for you. We will do our best to be prompt and to estimate the correct time needed for your appointment; however emergencies do arise. Please allow enough time for us to provide our best service for you. We believe that quality is more important than speed. If there are delays, you can be sure that it is because careful attention is being given to patients' needs. You will receive the same competent, professional care as soon as possible.

**MISSED APPOINTMENTS** – **If it is necessary to change an appointment, we expect you to call at least 24 hours in advance** (our telephone is answered 24 hours a day, seven days a week). Our policy is to charge for missed appointments or cancellations that happen without 24 hours notice. **Repeated missed appointments will lead to discharge from the practice.**

**Charges** – Our Practice is committed to providing the best treatment possible for our patients and our fees reflect what is "usual and customary" in our area. **Full payment is due at the time of service.** Please understand that payment of your bill is considered a part of your treatment. We accept cash, check, Visa, MasterCard, Discover and American Express.

**Insurance** – If we are not assigned providers for your insurance you will need to pay us for your services and we will give you a receipt, which you can submit to your insurance company for reimbursement. In the event that your insurance company sends the reimbursement to us, we will send a refund to you. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. The patient and/or parent or guardian is legally responsible for the bill. When our doctors are assigned providers, we bill the insurance company for you. **Please be aware that cosmetic services and skin care products are not covered by insurance and will be your responsibility.** If you have any questions or concerns about your insurance, please contact your agent.

**Medicare** – We will be happy to bill Medicare for you. We participate in Medicare and accept Medicare assignment of benefits. Please remember to include all supplemental insurance(s) as this information is required by Medicare laws.

It is a pleasure to serve you. We look forward to a long and positive relationship.

101 Park Place  
San Ramon, CA 94583  
phone: (925) 743-1488  
fax: (925) 743-1277

web site: [www.SanRamonDerm.com](http://www.SanRamonDerm.com)



GENERAL CONSENT AND FINANCIAL AGREEMENT, SIGNATURE ON FILE AND CONTACT INFORMATION

1. **Consent to Treatment:** I, the undersigned, hereby consent to medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedures and any subsequent treatment as deemed necessary as long as the risks and complications are discussed with me prior to the procedure. I understand that no guarantee has been made as to the results that may be obtained.
2. **Release of Information:** I authorize the release of any or all medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.
3. **Financial Policy:** Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. **We submit medical claims to participating insurance companies as a courtesy to our patients. It is your responsibility to pay your applicable co-payments, co-insurance, deductibles and for any non-covered and/or cosmetic services.**
4. **Assignment of Insurance Benefits:** I hereby authorize payment of medical benefits to the treating physician/practice. I understand that I am responsible for any health insurance deductible, co-payments, co-insurance and non-covered services.
5. **Acknowledgement:** My signature below acknowledges that I have read and understand each of the preceding sections 1 through 4.

\_\_\_\_\_ (Patient or Person Authorized to Consent)

\_\_\_\_\_ (Date)

\_\_\_\_\_ (Print Name if other than Patient)

\_\_\_\_\_ (Relationship to Patient)

**Medicare Patients Read and Sign Below**

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

*I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.*

\_\_\_\_\_ (Signature as it appears on Medicare Card)

\_\_\_\_\_ (Date)

***\*Medicare/Medical Patients:*** *We are not members of Medigap (Medical). Medicare covers 80% of allowed charges after your deductible has been met, you will be responsible for the 20% remaining balance.*

**Do you give our office permission to discuss your medical information with family members?**

Yes  No    If yes, please provide their names and phone number below:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # Day: \_\_\_\_\_ Phone # Evening: \_\_\_\_\_

**Emergency contact information:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**May we leave personal medical information on your answering machine at home?**  Yes  No

**May we e-mail personal medical information to you?**  Yes  No

E-mail address: \_\_\_\_\_



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**Patient Consent For Use And Disclosure  
Of Protected Health Information**

With my consent, Advanced Laser & Skin Care Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Advanced Laser & Skin Care Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Advanced Laser & Skin Care Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Advanced Laser & Skin Care Center's Privacy Officer at 101 Park Place, Suite 101, San Ramon, California 94583.

With my consent, Advanced Laser & Skin Care Center may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Advanced Laser & Skin Care Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Advanced Laser & Skin Care Center may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Advance Laser & Skin Care Center restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Advanced Laser & Skin Care Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Advanced Laser & Skin Care Center may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patients Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian





**Missed Appointment Policy**

**We appreciate your choosing our office for your cosmetic dermatology needs.**

**If you are unable to keep your appointment, we ask that you provide us with at least 24 hours notice. Your courtesy makes it possible for us to give your appointment to another patient. If you fail to cancel your appointment 24 hours ahead of the scheduled time (or by 5 PM on Friday for Monday appointments), we will bill \$50 to your account.**

**Thank you.**

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**Signature**

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**Please Print Name**

**Date**

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