

PT ACCOUNT # \_\_\_\_\_

NAME: LAST: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SEX (M) (F) EMPLOYER \_\_\_\_\_

OCCUPATION \_\_\_\_\_ BUSINESS ADDRESS \_\_\_\_\_

EMAIL \_\_\_\_\_ HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELLULAR \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SS# \_\_\_\_\_

REFERRED BY \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**INSURANCE INFORMATION:**

PRIMARY INSURANCE CARRIER \_\_\_\_\_ PHONE \_\_\_\_\_

CLAIMS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

POLICYHOLDER (NAME ON CARD) \_\_\_\_\_

ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

IF YOU ARE **NOT** THE POLICYHOLDER, **PLEASE PROVIDE THE FOLLOWING:**

POLICYHOLDER'S DATE OF BIRTH \_\_\_\_\_

POLICYHOLDER'S SSN# \_\_\_\_\_

PATIENT'S RELATIONSHIP TO POLICYHOLDER \_\_\_\_\_

**PATIENTS WHO ARE MINORS WHO ARE PRESENT WITHOUT A GUARDIAN**

IF YOU ARE A MINOR, THE INSTITUTE REQUIRES WRITTEN AUTHORIZATION FROM A LEGAL GUARDIAN THAT WE MAY CONDUCT A MEDICAL EXAM AND / OR TREATMENT WITHOUT THE PRESENCE OF A LEGAL GUARDIAN.

<b>TO BE COMPLETED BY LEGAL GUARDIAN &amp; FAXED TO INSTITUTE AT (310) 828-8504.</b>	
I AUTHORIZE _____ TO BE SEEN WITHOUT A LEGAL GUARDIAN	
PRESENT.	SIGNATURE _____ RELATIONSHIP _____
	DAYTIME TELEPHONE _____ DATE _____

**ACKNOWLEDGEMENT OF RECEIPT:** I hereby acknowledge that I have received a copy of Ava T. Shamban MD., Inc.'s Notice of Privacy Practices.

→ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**May we leave confidential medical messages on your voice mail? Yes \_\_\_ No \_\_\_**

**Please note preferred phone number: (\_\_\_\_) \_\_\_\_\_**

**LASER INSTITUTE For Dermatology and European Skin Care**

2021 Santa Monica Boulevard Suite 600E

Santa Monica, California 90404

Phone: 310-828-2282 Fax: 310-828-8504

**AVA MD**

9915 South Santa Monica Boulevard

Beverly Hills, California 90212

Phone: 310-843-9915 Fax: 310-843-9925

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**AVA T. SHAMBAN, MD., INC**  
**Financial Policy**

Payment is expected as services are rendered. We accept cash, Visa, MasterCard, and American Express. We do not accept checks. Unfortunately, gratuity cannot be added to credit card transactions.

For those patients who are covered by insurance, we will be happy to bill on your behalf, whenever medically applicable, as long as we are a contracted provider with your insurance company. Any co-pays, co-insurance, and/or deductibles as specified by your policy will be collected on the day of service.

Verification of benefits is NOT a guarantee of coverage. Medical necessity is up to the determination of your insurance provider. You the patient may be responsible for services even if Dr. Shamban is contracted with patient's insurance company.

If we are not a provider, we will collect payment at the end of your visit, and provide a statement for you to submit to your insurance company for direct reimbursement.

Any outstanding balance that is your responsibility will be expected to be paid in full within 30 days of notification.

Thank you,  
Dr. Ava T. Shamban and Staff

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I understand that I will be expected to pay for all applicable fees the day of service.  
I understand that I am responsible for any balances not covered by insurance.  
I will assume responsibility of notifying this office of any changes in insurance coverage.

I authorize any insurance company providing me with medical insurance to pay directly to Ava T. Shamban, MD., or her associates, the amount due in my pending claim for basic medical, major medical or surgical treatment. (If applicable).

I authorize the offices of Ava T. Shamban, MD., Inc. to release to any company providing me with medical insurance any information, including the diagnosis and the records of all treatments and/or examinations provided to me by Ava T. Shamban MD for the purpose of billing. (If applicable).

I agree to this financial policy and I have read and received a copy of this document.

→ **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**PLEASE TELL US ABOUT YOUR SKINCARE REGIMEN:**

AM CARE

Cleanser: \_\_\_\_\_

Prescription Products: \_\_\_\_\_

Facial Day Cream: \_\_\_\_\_

Sunscreen: \_\_\_\_\_

PM CARE

Cleanser: \_\_\_\_\_

Prescription Products: \_\_\_\_\_

Facial Night Cream: \_\_\_\_\_

Provider Notes

Provider Notes

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**COSMETIC INTEREST QUESTIONNAIRE**

**Please check all that apply any interest to you:**

- |   |   |
|---|---|
| <input type="checkbox"/> Acne                                       | <input type="checkbox"/> Micro-Dermabrasion       |
| <input type="checkbox"/> Age Spots/Brown Spots                      | <input type="checkbox"/> Removal of Face Veins    |
| <input type="checkbox"/> AHA and Glycolic Peels                     | <input type="checkbox"/> Removal of Leg Veins     |
| <input type="checkbox"/> Birthmarks                                 | <input type="checkbox"/> Retin-A or Renova        |
| <input type="checkbox"/> Botox Cosmetic (Botulinum Toxin Type A)    | <input type="checkbox"/> Sunscreen Advice         |
| <input type="checkbox"/> Chemical Peels                             | <input type="checkbox"/> Skin Rejuvenation        |
| <input type="checkbox"/> Collagen/Restylane/Juvederm Filler Therapy | <input type="checkbox"/> Skincare Advice/Products |
| <input type="checkbox"/> Facials and Eye Treatments                 | <input type="checkbox"/> Spider Vein Treatment    |
| <input type="checkbox"/> Hair Removal                               | <input type="checkbox"/> Tissue Tightening        |
| <input type="checkbox"/> Laser Resurfacing                          |   |
| <input type="checkbox"/> Laser Treatments                           |   |

**AVA T. SHAMBAN, MD., INC  
THE LASER INSTITUTE FOR DERMATOLOGY  
AND EUROPEAN SKINCARE**

**Cancellation Policy**

For **spa, laser, and cosmetic** appointments, we have a 24 hour notification policy. Requests for reschedules or cancellations must be made with office personnel **24 hours prior** to the appointment date in order to avoid a cancellation fee.

Fees for short notice are as follow:

Laser Appointments	\$100.00
Cosmetic Appointments	\$100.00
Spa Appointments	\$100.00 (or less)

I have read this policy and understand that I will be charged for short notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_