DOYLESTOWN FAMILY MEDICINE

Welcome to Doylestown Family Medicine. In an effort to provide you with the most enjoyable and beneficial experience possible, we ask that you complete the following questionnaire accurately and to the best of your ability. This document is designed to better help us determine the actual cause and effects of your specific condition. As a result, we can better inform you as to what procedure and/or program would be best suited for you as an individual. All information given remains private and confidential. This cover sheet will not become a part of your patient file.

Thank you

PATIENT INFORMATION (please print)

☐ MR. ☐ MRS. ☐ MS. ☐ MISS. ☐ DR. Sex: ☐ MALE ☐ FEMALE Date of Birth: __ /__ /__

First Name: _____ Last Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____)_____ Work Telephone: (_____)_____ Ext: _____

Cellular Telephone: (_____)_____ E-mail Address: _____

Occupation: _____ Marital Status: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWER

Spouse's Name: _____ Birth Date: ____/____/____

In Case of Emergency Contact: _____ Telephone: (_____)_____

Did Anyone Refer You To Us? ☐ YES ☐ NO If YES, who? _____

Have you Ever Seen Any of Our Acivertisments? ☐ YES ☐ NO

If YES, Which One(s)?

_____

_____

DOYLESTOWN FAMILY MEDICINE

*******OFFICE USE ONLY*******

Ethnicity:_____

Notes:_____

TREATMENT FEES

Procedure Details:

_____

_____

_____

Treatment Fee:

_____

_____

DFM Representative

_____

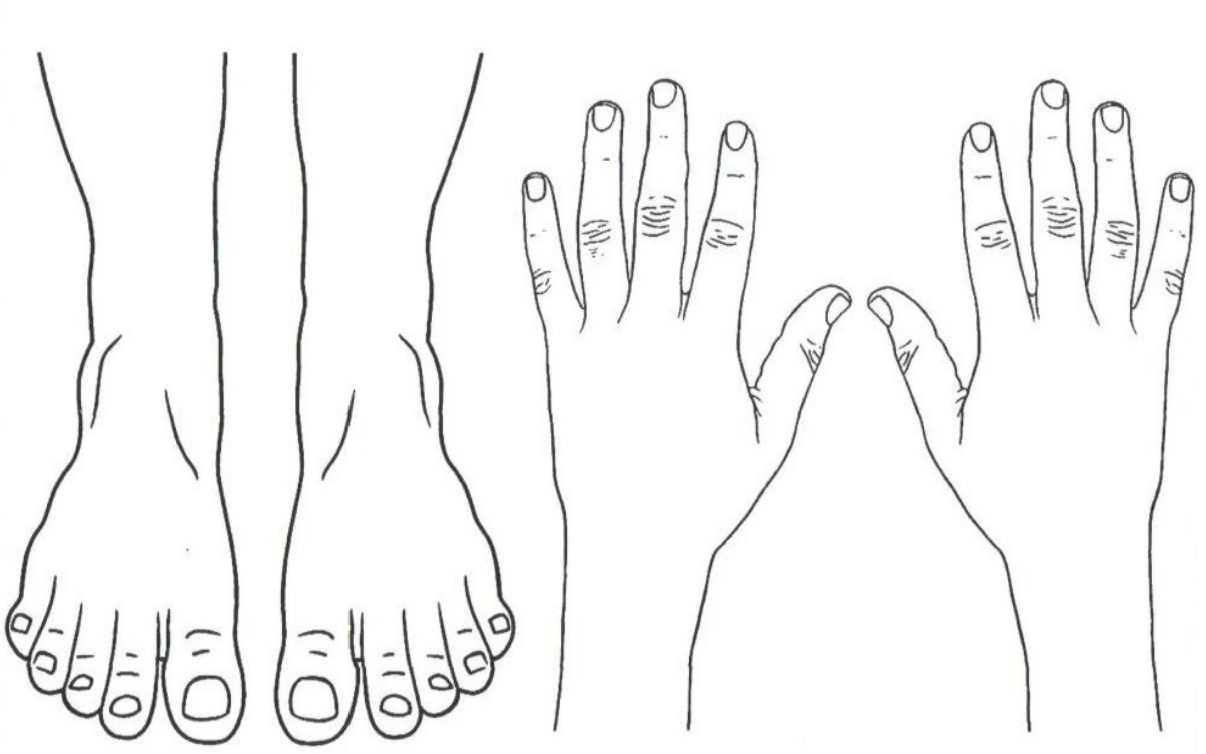
Patient Signature-Indicates Receipt

Date:_____

PATIENT INTAKE FORM
(please review list below and discuss any concerns you might have with any of our Clinicians)

My interest for treatment is: ☐ Toe Nail Fungus ☐ Finger Nail Fungus

Please mark the specific anatomical locations where you would like treatment:



Right Foot Left Foot Left Hand Right Hand

DOYLESTOWN FAMILY MEDICINE

Patient Consent (please print)

I duly authorize Doylestown Family Medicine and their designated Staff to utilize the following device to perform my desired service:

☐ Q-Clear Laser System

Nail Fungus Removal

(Onychomycosis)

For the above services I agree to pay a total of $_____ in _____ payment(s).

First Name:_____

Last Name:_____

PATIENT INFORMED CONSENT - NAIL FUNGUS REMOVAL

Q-Clear Laser System:

I understand that the Q-Clear Laser System is a prescription medical device. It is a flash lamp pumped, high peak power solid state laser producing intense, gentle, painless pulses of invisible light at wavelengths of 1064 nm in the near infrared range. It is intended for use only by practitioners or their designated staff

I understand that the Q-Clear Laser System has been FDA-Approved for the safe and effective treatment of Onychomycosis, or toe nail fungus and I authorize its use by Doylestown Family Medicine for these purposes. I also understand that while the Q-Clear Laser has been deemed extremely safe, I accept all risks from factors known and unknown along with any rare side effects that may be attributed to this device.

Patient Initials:_____

I understand that individual results may vary depending upon individual factors including medical history, skin type, patient compliance with pre/post treatment instructions, as well as individual genetics and personal response to treatment. I also understand that treatment results can take many months and even up to one year to fully realize the desired end point.

I certify that I have been fully informed as to the nature and purpose of the procedure, expected outcomes, and possible complications. I am fully aware that my condition is of cosmetic concern and the decision to proceed is based solely upon my expressed desire to do so. I confirm that I have informed the staff of any current or past medical condition, disease, or medications taken.

I consent to the taking of photographs and authorize their anonymous use for the purpose of medical audit and education.

By signing below I acknowledge that the information I have provided is accurate and true to the best of my knowledge, that I have been given the opportunity to ask questions, and that I have read and fully understand the above statements and the contents of this Consent Form.

_____	_____	_____
Patient Name - Please Print	Patient Name - Signature	Date
_____	_____	_____
DFM Representative- Please Print	DFM Representative– Signature	Date

DOYLESTOWN FAMILY MEDICINE

NOTICE OF PRIVACY PRACTICES-Part 1 of 2

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A federal regulation, known as the "HIPAA Privacy Rule" requires that we provide detailed notice in writing of our privacy practices.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this notice, we describe the ways that we may use and disclose your protected health information about you. The H IPAA Privacy Rule requires that we protect the privacy of health information that identifies an Individual or where there is a reasonable basis to believe the information can be used to identify an individual. This information is called "Protected Health Information" (PHI). This notice describes your rights and our obligations regarding the use and disclosure of PHI. We are required by law to:

-Maintain the privacy of PHI about you;

-Give you this notice of our legal duties and privacy practices with respect to PHI; and

-Comply with the terms of our notice of privacy practices that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

A. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The following categories describe the different ways we may use and disclose PHI for treatment, payment, or health care operations. The examples included with each category do not list every type of use or disclosure that may fall within that category.

Treatment: We will use and disclose your protected health/ personal information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health/personal information as necessary, if, as a result of our services you require treatment by a physician. Your protected health/ personal may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health/personal information will be used, if request, to obtain payment for your services. For example, if you desire to finance the costs of your treatments, this may involve disclosing relevant protected private information in order to obtain approval.

Health Care Operations: We may use or disclose, as needed, your protected health/personal information in order to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the Registration Desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health/personal information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health/personal information in the following situations without your authorization. These situations include: as required by law; public health issues as required by law; communicable diseases; health oversight; abuse or neglect; Food and Drug Administration requirements; legal proceedings; law enforcement; coroners, funeral directors and organ donation; research; criminal activity and national security; workers' compensation; inmates; required uses and disclosures. Under the law, we must make a disclosure to you and, when required by the Secretary of the Department of Health and Human Services, to investigate or determine our compliance with the requirements of Section 164.500.

_____

Patient Initials

DOYLESTOWN FAMILY MEDICINE

NOTICE OF PRIVACY PRACTICES-Part 2 of 2

III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you:

Right to Request Restrictions: You have the right to request additional restrictions on the PHI that we may use for treatment, payment, and health care operations. You may also request additional restrictions on our disclosure of PHI to certain individuals involved in your care or benefit coverage that otherwise are permitted by the Privacy Rule. Your request must state the specific restriction request and to whom you want the restrictions to apply.

We are not required to agree to your request. If our Medical Director believes it is in your best interest to permit use and disclosure of your protected health/personal information, your PHI will not be restricted. You then have the right to another service provider.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding PHI in a certain manner or at a certain location. You have the ri1t to obtain a paper copy of this notice from us. You must make your request in writing and you must specify how you would like to be contacted (for example, by regular mail to your post office box and not your home). You may also agree to accept this notice alternatively (electronically). We are required to accommodate reasonable requests.

Right to Inspect and Copy: You have the right to request the opportunity to inspect and receive a copy of PHI about you in certain records that we maintain. Under Federal Law, however, this does not include information gathered or prepared for a civil, criminal, or administrative proceeding, and protected health/personal information that is subject to law that prohibits access to protected PHI information. We may deny your request to inspect and copy PHI only in limited circumstances. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor, and supplies used to meet your request.

Right to Amend: You have the right to request that we amend PHI about you as long as such information is kept by or for our office. To make this type of request, you must submit your request in writing. You must also give us a reason for your request. We may deny your request in certain cases, including if it is not in writing or if you do not give us a reason for the request.

Right to Receive an Accounting of Disclosures: You have the right to request an accounting of certain disclosures that we made of PHI about you.

We reserve the right to change the terms of this Notice and will inform you by mail of any changes, you then have the right to object or withdraw as provided in this Notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health/personal information. If you have any objections to this form, please ask to speak with our HIPPA compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

_____

Patient Full Name (please print)

_____ _____

Patient Signature Date

DOYLESTOWN FAMILY MEDICINE

PRE/POST TREATMENT INSTRUCTIONS - NAIL FUNGUS

Pre-Treatment:

• At least 24 hours prior to treatment, remove any and all nail polish from every nail on the hand or foot being treated.

• Shave any hair that is present on your toes or fingers to avoid any unnecessary laser absorption.

• If possible, please clip or trim your nails in a semi-circular fashion (versus a squared off manner).

• File down nail build-up if mild. If nail is significantly thickened, we will perform debridement to eliminate the thickness prior to laser treatment.

• ensure that you are wearing clean, dry shoes and socks, or open toes shoes. Do not wear the same shoes to your appointment that you wore the previous day.

Post-Treatment:

• You can resume normal activities immediately.

• Do not use artificial nails during the period of time that you old nail is growing out.

• It is recommended to use anti-fungal products which can be purchased from your provider or over the counter.

• Since your nails are made up largely of protein, eating a healthy diet which includes ample protein will speed up the growth of new clear nail and improve strength. High protein foods include liver, milk, cheese, beans, yogurt, fish, and eggs.

• Your diet should also include iron rich foods. Iron deficient diets can cause spoon-shaped growth and weakness in your nails. Iron rich foods include dates, raisins, liver, whole grains, and dark green leafy vegetables.

• The B-vitamin Biotin plays a major factor in strong nail health. Biotin can be taken as a supplement and can help prevent breakage, strengthen the nail, and aid in the repair of brittle nails. Foods containing biotin include almonds, Swiss chard, peanuts, goat's milk, eggs, yogurt, and tomatoes.

Post-Treatment Cont.:

• Adhere to Nail Fungus Prevention guidelines to reduce or eliminate the possibility of future nail fungus.

Nail Fungus Prevention

• Keep your nails short, dry and clean. Trim nails straight across and file down thickened areas. Thoroughly dry your hands and feet, including between your toes, after bathing.

• Wear appropriate socks. Synthetic socks that wick away moisture may keep your feet dryer than do cotton or wool socks (you can also wear synthetic socks underneath other socks). Change them often, especially if your feet sweat excessively. Take your shoes off occasionally during the day and after exercise. Alternate closed-toe shoes with open-toe shoes.

• Use an antifungal spray or powder. Spray or sprinkle your feet and the insides of your shoes. Spraying your shoes with Lysol spray will also disinfect them.

• Wear rubber gloves. This protects your hands from overexposure to water. Between uses, turn the rubber gloves inside out to dry.

• Don't trim or pick at the skin around your nails. This may give germs access to your skin and nails.

• Don't go barefoot in public places. Wear shoes around public pools, showers and locker rooms.

• Choose a reputable manicure and pedicure salon. Make sure the salon sterilizes its instruments. Better yet, bring your own.

• Give up nail polish and artificial nails. Although it may be tempting to hide nail fungal infections under a coat of pretty pink polish, this can trap unwanted moisture and worsen the infection.

• Wash your hands after touching an infected nail. Nail fungus can spread from nail to nail.

Personal Information (please print)

Sex: ☐ Male ☐ Female

Date of Birth:___/___/___

First Name:_____

Last Name:_____

DOYLESTOWN FAMILY MEDICINE

Q-CLEAR LASER SYSTEM NAIL FUNGUS REMOVAL GUARANTEE

The Q-Clear Laser System is a Class IV Medical Device which has been specifically FDA Approved in safety and efficacy for the treatment of onychomycosis (nail fungus). Controlled and extensive Clinical Trials were performed on both genders and of multiple ethnic backgrounds. The patient satisfaction rate was recorded at 100% with a success rate as measured by significant to total nail plate clearance in 97% of cases without any adverse side effect. These results were obtained from one, simple treatment.

TREATMENT GUARANTEE

Patient who has been diagnosed by Doylestown Family Medicine to suffer from onychomycosis shall undergo one (1) single treatment on the Q-Clear Laser System for the eradication of nail fungus. Effective and successful results are not immediately visible. It is necessary for the old nail to grow out and for the new, clear nail to grow in its place. The time frame for this process varies individually and by age; however, most people should begin to see the appearance of new, clear nail within 8 - 12 weeks (2 - 3 months). A completely new nail should appear some time after six months from the date of the procedure. For some patients, it may take up to 12 months for a new nail to completely replace the old one.

TERMS AND CONDITIONS

- Pre-treatment photo will be taken prior to the application of the Q-Clear Laser System treatment
- Patient can request a treatment review no sooner than 180 days, or six months after initial treatment if NO NEW CLEAR NAIL has formed. DFM Representative will assess the progress to date and will re-treat at that time if required.
- If Patient is not satisfied with the results of initial treatment, they MUST advise Doylestown Family Medicine within one year of the date of the initial treatment to arrange an assessment by a DFM representative and subsequent re-treatment.

Patient Name - Please Print	Patient's Signature	Date