



Directions to the Office

If you are traveling North on I-95:

Exit Butler Boulevard as you come off the exit ramp, stay in the right lane and proceed straight toward the light, which is Belfort Road. You will see signs for Belfort Road. Go straight toward Belfort but stay in the middle lane (the right lane of the lanes going left) and bear left at the light on to Belfort which will take you under the Butler overpass. Once on Belfort, go straight you will see St. Luke's Hospital on your right. You will pass St. Luke's Hospital and continue straight to the next light, Gate Pkwy West, turn right. Once on Gate Pkwy West, go straight about half quarter mile. The medical complex (Gate Parkway West Professional Center) is on the left. Our office building is to the left next to Gulani Vision Institute.

If you are traveling South on I-95:

Take the Butler Exit turn left off the ramp on to Butler and immediately get into the right lane and take the first exit, which is the Belfort Road. You will see signs for Belfort Road. Go straight toward Belfort but stay in the middle lane (the right lane of the lanes going left) and bear left at the light on to Belfort which will take you under the Butler overpass. Once on Belfort, go straight you will see St. Luke's Hospital on your right. You will pass St. Luke's Hospital and continue straight to the next light, Gate Pkwy West, turn right. Once on Gate Pkwy West, go straight about half quarter mile. The medical complex (Gate Parkway West Professional Center) is on the left. Our office building is to the left next to Gulani Vision Institute.

If you are traveling West on JTB (from the beach):

Take Southside North, get in the left lane and turn left at Gate Pkwy West, go about a mile and a half, you will see the medical complex (Gate Parkway West Professional Center) on the right. Our office building is to the left next to Gulani Vision Institute.



PATIENT REGISTRATION

NAME: _____ DATE: _____

Welcome to Quinn, MD! We are privileged to have the opportunity to include you as one of our patients and will make every endeavor to ensure that your visits with us are enjoyable. Please take a few moments to answer the following questions so we can be of better service to you now and in the future. Keep in mind, your comments about our services and staff are welcome at anytime during or after your visit.

How did you hear about Quinn, MD?

___ Brochure ___ Folio ___ Times Union ___ TV
___ Internet ___ Yellow Pages Other _____

What information did you receive about the treatment you are seeking before this visit?

How can we improve our communication with you? _____

Address: _____ Home Phone: _____
City, St., Zip _____ Work Phone: _____
Social Security Number: _____ Cell Phone: _____
Date of Birth: _____

Email Address _____
Employer: _____ Occupation: _____

Marital Status: S M D W
Spouse: _____ Work Phone: _____

Nearest Relative: _____ Home Phone: _____
Who should we contact in case of an emergency? _____
Relationship: _____ Phone Number _____

INSURANCE/FINANCIAL INFORMATION

Primary Insurance Company: _____
Policy Holder: _____
Date of Birth: _____ Relationship to Patient: _____
Is this Policy a: HMO PPO PPC POS
Social Security Number: _____ Employer: _____
Secondary Insurance Company: _____
Policy Holder: _____
Date of Birth: _____ Relationship to Patient: _____
Is this Policy a: HMO PPO PPC POS
Social Security Number: _____ Employer: _____
Credit Card you wish to use at this office: VISA MASTERCARD AMERICAN EXPRESS DISCOVER
Card Number: _____ Expiration Date: _____

Person Responsible for this account:

Name: _____ Phone Number: _____
Address: _____ Employer: _____
Who REFERRED you to our office?
Name: _____ Address: _____



Patient Skin History and Analysis

Name: _____

Date: _____

Sports/Hobbies: _____

Occupation: _____

General Information:

Have you ever seen a doctor for your skin? _____ For what procedure? _____

History of Skin Cancer (date, type, location): _____

Are you under care or do you have the following?

- Diabetes Heart Condition Pacemaker Seizures Hepatitis Hemophilia
- Lupus Porphyria Photosensitivity HIV+

Have you or are you using any medications:

- Accutane Retin-A Topical Antibiotics Diuretics Birth Control
- Oral Antibiotics

Have you ever been had any prior cosmetic peels? TCA Glycolic Jessner's
 Other _____

List any allergies: _____
(Aspirin, Citrus fruits, Milk products, Aspirin, Benzoyl Peroxide, Skin care products)

Are you pregnant, lactating or going through menopause? YES NO

Did you develop hyper-pigmentation from these hormone changes? YES NO

Do you get cold sores or fever blisters on the lips or face? YES NO

How many ounces of water do you drink per day? _____

How much caffeine do you drink per day? _____

How do you rate your skin?

- | | | | | |
|-----------------|----------------|---------------|-------------|-----------------------|
| ___ Dry | ___ Normal | ___ Oily | ___ Acne | ___ Scarring |
| ___ Blackheads | ___ Pimples | ___ Sensitive | ___ Rosacea | ___ BrokenCapillaries |
| ___ Whiteheads | ___ Fine lines | ___ Wrinkles | ___ Sagging | ___ Crow's feet |
| ___ Brown spots | ___ Tight | ___ Flaky | ___ Shiny | ___ Dehydrated |
| ___ White spots | | | | |

Please check the products you are currently using and list the BRAND NAMES:

- Cleanser _____ Soap _____ Toner _____
- Moisturizer _____ Night Cream _____ Other _____
- Eye Cream _____ Toner _____ Mask _____
- Scrub _____ Sunscreen _____

Sun History - How does your skin respond to the sun during the first 15 minutes of exposure?

- ___ I Always burns, never tans (Caucasian)
- ___ II Usually burns, tans with difficulty (Caucasian)
- ___ III Sometimes burns, tans average (Caucasian, Hispanic, Asian)
- ___ IV Rarely burns, tans easily (Hispanic, Asian, African American)
- ___ V Very rarely burns, tans easily (Hispanic, Asian, African American)
- ___ VI Almost never burns, tans easily (African American)

Patient Signature: _____

Clinician Signature: _____



Tattoo Removal Information and Consent Form

This form is designed to provide you with the information you will need to make an informed decision about whether to have treatment performed.

How many treatments are needed and how often? – The time required for a tattoo to fade depends on many factors such as the depth of penetration of the ink, the color of the ink, the density of the ink, the type of ink used, whether the tattoo was done by an amateur or professional, the patient's immune system and skin type, and location of the tattoo. It is not unusual to require more than 12 treatments, done over several years, to achieve maximum resolution. In some cases it may require more treatments depending on the factors listed above. Treatments are scheduled 6-8 weeks apart.

What is Acid Tattoo Removal? - In some cases, we will rotate between laser treatment and acid treatment. The acid is composed of hops, water lily extract, planeain extract, tea and distilled water. The acid is applied into the tattoo through a rotary needle machine, and interacts with the pigment. Your practitioner will decide which treatment would best suit you.

How long does it take to see a difference? – It is not uncommon for it to take a year or more before there is significant fading. Most people that commit to this treatment need to be patient, persistent and committed to the long haul. Tattoos fade reliably but slowly.

What color tattoos respond best? – Black and blue work best. Red also responds okay. Yellow is very difficult and green tattoos may end up yellow because only the blue component of the green color may respond.

Do all tattoos respond? – A non-professional tattoo may not respond to treatment. This is because it was probably placed at the wrong level in the skin where it may not be responsive to the laser light.

Is the treatment painful? – A local anesthetic is injected into the skin with tiny needles and will make the procedure completely painless.

What will it look like immediately after treatment and a few days later? – As the tattoo is treated with the laser, small white marks will appear all along the tattoo. These will go away within hours. Over the next few days some crusting of the skin may occur. The acid treatment takes longer to recover, and will be oozy for a day or two. Healing time usually takes 7-10 days for the acid treatment.

How long does it take? – A tattoo that occupies approximately 2 inches by 2 inches will take 10 to 15 minutes to treat with the laser, and about 15-30 minutes with the acid.

Who performs the treatment? – A physician or a nurse practitioner administers tattoo treatments.

Pre-Treatment Instructions – Avoid sun/tanning for 2 weeks prior to treatment. Shave the area to be treated and remove all makeup or cosmetics prior to treatment.

Post-Treatment Instructions – Avoid sun/tanning for 2 weeks after the treatment. For the laser, apply antibiotic ointment to treated area twice a day for 1 week. Keep area covered, and avoid getting it wet. For the Acid



treatment, apply antibiotic ointment to area for one day only. Then allow area to dry and crust naturally. The area will likely scab, and the scab flakes off in 7-10 days.

Contraindications to Procedure – We cannot treat tattoos around the eyes or permanent makeup. Injectable lidocaine may not be used on digits (fingers or toes). We do not treat patients with history of keloid scarring. We do not treat patients who are pregnant, diabetic, active infections, compromised immune system, coagulation disorders, photosensitivity, or skin types V or higher.

Risk of Procedure – You may experience possible discomfort during the procedure, temporary redness or swelling immediately post treatment, allergic reaction to anesthetic used, possible allergic reaction to the initial dye used as it is released into the immune system, scabbing or crusting of the skin, scarring or changes in natural pigmentation of the skin. Hyperpigmentation may result in sun-exposed areas and hypopigmentation may be seen in darker skinned people.

Cost of Treatment – The cost is \$100 per treatment for tattoos 2” x 2” or smaller. An additional \$50 charge will be applied for every half inch over.

Estimation of Tattoo Cost Per Treatment: _____

The practice of medicine and surgery is not an exact science, and therefore we cannot guarantee results. I understand it is important to keep the medical staff informed of any changes in my conditions. I understand that I need to be accessible for follow up visits. By signing below, I acknowledge that I have read the foregoing informed consent form and that I understand the risks of laser tattoo treatment, acid tattoo treatment, alternatives to treatment, and the risks of treating or not treating this condition. I hereby consent to treatment.

Patient Name

Date

Quinn, MD representative



Patient Policies: Appointment, Records, Disputes and Informed Consent to Treatment

APPOINTMENTS

All appointment cancellations require at least 24 hours notice unless an emergency (documented) arises. Failure to give a 24-hour cancellation notice, or simply not showing will result in a \$25 office visit assessment. Call 904-296-0900 to cancel. Email notification is not an accepted form of cancellation.

QUINN, MD SIGNATURE SERVICES

Signature Services are the Fraxel laser, Varicose Vein treatments, Vein Removal procedures, and Laser Hair removal treatment greater than an hour. All Signature Service cancellations require at least 24 hours notice unless an emergency (documented) arises. Failure to give a 24-hour cancellation notice will result in a \$100 Signature Service assessment. Call 904-296-0900 to cancel.

MEDICAL RECORDS POLICIES

For a copy of your medical records, please allow us 10 business days notice. There will be a charge of \$1.00 per page for the first 25 pages and \$0.25 for every page after. You will need a signed medical records release form to proceed.

Payment is due the day of the service unless previous arrangements have been made. Our office often distributes coupons to patients. Only one coupon can be redeemed per visit and it can not be combined with another pre-arranged discount. Our office is proud to offer financing through CareCredit and CapitolOne. These are no interest payment plans for 12 months. Please see representative for information.

DISPUTES AND INFORMED CONSENT TO TREATMENT

In the event of any dispute between me and Quinn, MD, and/or any other person associated with Quinn, MD, I agree to submit a written claim of such dispute to Quinn, MD within on (1) year of this date. I acknowledge and agree that failure to timely make such a claim shall constitute a waiver of any and all rights and remedies related thereto.

Any claim made in accordance with the paragraph above, including, without limitation, claims for Professional Liability, Personal Injury, Contract, Warranty or other breach of duty, or the coverage of this arbitration provision, shall be settled by arbitration pursuant to the Florida Arbitration Code. By agreeing to arbitrate, I am waiving my right to a jury trial. Any such arbitration shall be conducted in Jacksonville, Florida. The arbitration of such issues, including determination of the amount of any damages suffered, shall be to the exclusion of any resolution in a court of law. The decision of the arbitrators shall be final and binding upon me, my heirs, executors, administrators, successors and/or assigns.

In the event any action is initiated for any breach, fault, or default of any of the terms, conditions, or provisions of the Agreement, then the party in whose favor judgment shall be entered shall be entitled to have and recover from the other party all costs and expenses, including attorneys' fees.



All terms and conditions embodied in the Informed Consent to Treatment are to be interpreted and construed according to the laws of the State of Florida; any litigation would be filed in a Florida State Court.

If any part of this Informed Consent to Treatment is deemed to be unenforceable for any reason whatsoever, the remaining portions shall remain in full force and effect. Nothing herein shall be construed to constitute a waiver of, or any other limitation upon, any of the legal and/or equitable rights of Quinn, MD, all of which are hereby expressly reserved.

I understand that consent to arbitration is not a prerequisite to treatment at this clinic, and is voluntarily given by me. I understand there are other clinics where my needs can be addressed, but have chosen Quinn, MD even with all these conditions I have agreed to, and promises I have made,

Patient Signature

Date



NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 14, 2003* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Dr. Linda Quinn. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement. Furthermore, we will provide you with a treatment estimate describing or recommending treatment alternatives.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances. We reserve the right to discuss your payment options with the individual financially responsible for your treatment.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. In addition, this may require speaking with your primary care physician, obtaining information from hospitals and/or labs directly relating to your treatment. Your information may also be disclosed to laboratories for the purpose of ordering blood tests.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$1.00 for each page and the staff time including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.



AESTHETIC SCIENCE. LASER MEDICINE.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing or request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Dispensed Medications: You have a right to medication counseling by a provider in this office regarding any prescribed or dispensed medications.

HOW TO CONTACT US

Practice Name: Dr. Quinn MD Privacy Officer: Dr. Linda Quinn Telephone: (904) 296-0900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Privacy Practices.

Print Name: _____ **Signature:** _____ **Date:** _____

Office Use Only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign. Due to an emergency situation it was not possible to obtain an acknowledgement.
- We were not able to communicate with the patient. Other (please provide specific details) _____

Employee Signature: _____ **Date:** _____

8075 Gate Pkwy West, Suite 101 Jacksonville, FL 32216

Phone 904-296-0900 Fax 904-296-7597