Phone: (508) 936-1657
Fax: (888) 355-3778

Website: www.NorthboroDoctor.com
Instagram: DrNovikovSkinCare

Mikhail Novikov MD PC

PATIENT INFORMATION:

Last Name:_____ First Name: _____ Middle Initial:____

Date of Birth:_____ Sex: Male_____ Female_____ Social Security Number:_____

Street Address:_____

City:_____State:_____ Zip:_____

Email Address: _____ Home Phone: _____

Mobile Phone: _____ Work Phone: _____

How did you hear about us? _____

EMERGENCY CONTACT INFORMATION:

Name:_____

Relationship: _____

Home Phone: _____

Mobile Phone: _____

Work Phone: _____

VISITING NURSING COMPANY (If applicable):

Name: _____

Phone Number: _____

PREFERRED PHARMACY:

Name: _____

Address: _____

City or Zip Code:_____

Phone Number: _____

PRIMARY CARE PHYSICIAN:

Name: _____

Address: _____

City or Zip Code:_____

Phone Number: _____

REASON FOR VISIT TODAY:

General Appearance:_____

Duration:_____

Location:_____

Cause (If know):_____

Current Treatment:_____

Severity of Problem (Mild, Moderate, Severe):_____

Associated Signs/ Symptoms:_____

Other Comments:_____

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PAST MEDICAL HISTORY (Please check all the items below that pertain to you):

- ☐ Tobacco use (Current or history)
- ☐ Alcohol use (Current or history)
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinopathy
- ☐ Blindness
- ☐ Macular Degeneration
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ GERD
- ☐ Dysphagia
- ☐ Lupus
- ☐ Scleroderma
- ☐ COPD
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain
- ☐ Congestive Heart Failure
- ☐ Angioplasty
- ☐ Bypass
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ TIA
- ☐ Blood Clots
- ☐ DVT
- ☐ Hepatitis
- ☐ Anemia
- ☐ Sickle Cell
- ☐ Bleeding/Clotting Disorder
- ☐ Lymphedema
- ☐ Urinary Tract Infection
- ☐ Renal Insufficiency
- ☐ Dialysis
- ☐ Diabetes (Type:_____)
- ☐ Neuropathy
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Alzheimer's Disease
- ☐ Dementia
- ☐ Seizures
- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia
- ☐ Other:_____

_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY (Please check all the items below that pertain to you):

- ☐ Past history of significant sun exposure
- ☐ Past history of blistering sunburns
- ☐ History of tanning bed use
- ☐ Personal history of skin cancer:
  - ☐ Basal Cell Carcinoma
  - ☐ Squamous Cell Carcinoma
  - ☐ Melanoma
- ☐ Other:_____

Family history of malignant melanoma
- ☐ Yes
- ☐ No

Family history of non-melanoma skin cancer
- ☐ Yes
- ☐ No

PAST SURGICAL HISTORY (Procedure and date):

_____

MEDICATIONS:

☐ Medication list attached:

_____
_____
_____
_____

ALLERGIES:

☐ Allergy list attached

_____
_____
_____
_____

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Mikhail Novikov MD PC
Wound Care and Minor Surgery

Website: www.NorthboroDoctor.com
Instagram: DrNovikovSkinCare

Patient Consent for Photography/Videography

I consent for Mikhail Novikov, MD, PC to take medical photographs/videos of me, my child, or the person for whom I am legal guardian. I understand that the information may be used in my medical record, for purposes of medical teaching, or publication in medical textbooks, journals, and social media as I have designated below. I further consent for Mikhail Novikov, MD, PC to disclose photographs/videos and information relevant to my, my child's, or the person for whom I am legal guardian's current care to health care professionals involved in such person's medical care. By consenting to these medical photographs/videos I understand that I will not receive payment from any party. Refusal to consent to photographs/videos will in no way affect the medical care I will receive or for which I am eligible. If I have any questions or wish to withdraw my consent in the future I may contact Mikhail Novikov MD, PC at 508-936-1657. This consent is valid for ten (10) years from the date on which it is signed.

I agree to the use of my photos/videos for:

- ☐ Medical records
- ☐ Teaching purposes
- ☐ Medical publications

I understand that the photographs/videos may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photos/videos will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

- ☐ Website and social media

Although these photographs/videos will be used without identifying information such as my name, I understand that it is possible that someone may recognize me

-OR-

- ☐ Check here if you do not give consent, are a minor, or are for any other reason unable to provide consent

By signing below, I acknowledge that I have received a copy of this consent. I understand that I may inspect or obtain a copy of the health information used or disclosed subject to this consent.

_____ OR _____

Patient Signature

Power of Attorney Signature

Mikhail Novikov MD PC

Credit Card on File Authorization Form

Information to be completed by cardholder

The undersigned agrees and authorizes Mikhail Novikov MD PC to save the credit card indicated below on file.

Patient's name:

_____

Name as it appears on the Credit Card:

_____

Type of Credit Card: ▫ Mastercard ▫ Visa ▫ Discover ▫ Amex card

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date (MM/YY): __ / __

Security code on the back: _____

Credit Card Billing Address:

_____

I, _____ authorize the above medical practice to process the above credit card as "Card on File."

The Card on File will be charged for all outstanding copays and deductibles required by the insurance company, as well as remaining balance after insurance payment. This card may be used for non-covered products and services provided to the patient.

I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice at any time.

_____ Cardholder's signature

_____ Date

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Mikhail Novikov MD PC
Wound Care and Minor Surgery

Website: www.drnovikov.com
Email: admin@drnovikov.com

Missed Appointment Policy

All patients are required to give at least 24 hours advanced notice when canceling an appointment.

A missed appointment is defined as any appointment for which a patient does not arrive for as scheduled ("no show"), or is canceled without a minimum of 24 hours notice (same day cancellation).

Failure to give 24 hours notice ("Same Day Cancellation") or giving no notice at all ("No Show") will result in the following:

- 1st Missed Appointment: Written notice and $100.00 missed appointment fee billed or charged to credit card on file
- 2nd Missed Appointment: $100.00 fee and written notice of dismissal from the practice

Patients with an outstanding balance of missed appointment fees will NOT be allowed to schedule another appointment with us until the balance is paid in full.

Signature of Patient or Responsible Party:

Date:

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Office Patient Agreement

Appointments: We make every effort to see our patients on the same week or even on the same day. However it is not always possible. To schedule an appointment, call us at (508) 936-1657 ext. 1.

Referrals: It's is your responsibility to obtain referrals when necessary. Failure to do so may result in you being financially responsible for the services you receive at the time of your visit.

Non-Covered Services: Please be aware that some and perhaps all of the services you receive may not be covered or may be considered unnecessary by Medicare or other insurers.

Appointment No Shows/Cancellations: We appreciate you notifying us if you cannot make your appointment so that we can give that time to another patient. If you need to reschedule or cancel an appointment. Please call our office at least 24 hours in advance of your appointment time. If you are going to be more than 15 minutes late, we may have to reschedule so that your delay does not interfere with patients who arrive on time. Our policy is to charge $100 for patients who fail to show for their appointment or cancel with less than 24 hours notice. These charges will be your responsibility and billed directly to you. We reserve the right to terminate our relationship as a result of repeated missed appointments and late cancellations. Please refer to attached Missed Appointment Policy for details.

_____ (Patient initials) I consent to receive text messages or voice messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails, text messages, or voice messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. Our practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Payment Policy: Our practice participates with almost all area insurance plans. We offer very competitive and affordable cash rates for uninsured/underinsured patients and patients with insurance plans we do not

participate with. As a courtesy to you, our office staff files your insurance claim with health insurance plans. Please bring your insurance card with you at each and every office visit. We do not however assume responsibility of insurance coverage for the services we provide. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you have regarding your coverage.

With current health insurance system it is quite possible that your insurance company may deny legitimate service charges we bill on your behalf. If this is the case you will be responsible for the entire balance. You have a right to appeal your insurance company's decision by contacting the State at http://www.mass.gov/ocabr/docs/doi/ consumericss-complaint form.poi We have heard from several patients this is a powerful tool to make your insurance company reconsider. We are required by our contracts with health care plans to collect all co-pays and deductibles at the time of service. If we do not have a contracted arrangement with your insurance plan, you must pay in full at the time of service. If you have a service that is not covered by insurance, like some cosmetic procedures, this also must be paid in full at the time of your visit. We accept cash, check and major credit cards.

Depending on your insurance plan, you may also receive a separate bill for laboratory testing/biopsy/imaging we ordered. Some tests deemed necessary for your care may not be covered by your insurance company.

Prescription Refills: Please ask your provider to refill your prescription during your visit. Most of the time it is unsafe to refill prescriptions over the phone without re-assessing your medical condition.

Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and/ or you may be discharged from the practice. In such cases, you will be notified that you have 30 days to find alternative medical care. During that 30 day period, our provider will be able to see you only for urgent issues.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have the insurance coverage with and assign directly to Mikhail Novikov MD PC all my insurance benefits, if any, otherwise _____ payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. I further agree in the event of nonpayment, to bear the cost of collection and/or court cost and reasonable legal fees should this be required.

Signature of Insured or Responsible Party:

_____

Date:

_____

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Consent Form for Surgical Procedure(s) under Topical Anesthetic

Patient Name (Printed): _____Date:

Attending Physician: _____

Procedure(s): _____ (Identify specifically for each patient.)

Provider(s) performing the procedure(s): (Identify all providers who are actually involved in the procedure. In the event that the list of providers changes prior to the procedure, you will be notified of the change and asked to sign or initial an updated form.)

_____ _____
_____ _____
_____ _____
_____ _____

Regarding the aforementioned procedure(s):

1. I consent to the procedure(s) outlined above under local anesthetic.
2. I understand the procedure to be performed and that they may be performed on a weekly basis as medically necessary.
3. I understand the associated risks including without limitation infection, excessive bleeding and discomfort.
4. I am satisfied that I have received sufficient information to provide this consent, and I therefore do not request further information on the planned procedures.
5. I understand that the procedures are intended to relieve discomfort, control infection, improve quality of life, promote wound healing or provide diagnostic information.
6. I understand that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees or assurances have been made to me concerning the results of the above procedure. Furthermore, in the event of an emergency, I authorize whatever medical procedure or action deemed necessary by the above named physician.
7. I understand that I am entitled to a copy of this written consent.
8. I understand that I may revoke this consent at any time by providing notice to the above named physician.

_____ OR _____ Patient Signature Power of Attorney Signature

Witness one name signature: _____
Witness two name signature: _____

Informed Consent:
I have explained to the patient/person authorized to consent for patient, the nature of the procedures, including the risks and benefits, the possible complications and the alternatives to performing the procedures. The patient/authorized individual whose signature is shown above has indicated understanding of, and consent to the procedures listed above.

Signature of Attending Physician _____
Date: _____

Designation for Release of Medical Information to a Family Member, Friend Or Legal Representative

It is our responsibility to ensure that the provider-patient relationship is confidential. The Health Portability and Accountability Act (HIPAA) allows physicians and other healthcare providers to use their professional judgment on disclosing certain patient's personal health information to patient's family, friends, etc. without an authorization. This form is an aid to the providers in making a determination on disclosing such information. Mikhail Novikov MD PC (our practice) realizes that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your provider wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition and allow that person to be present in our office during your medical appointments. To enable that, we would ask that you complete the form listed below.

Please note:
This designation is valid until you cancel it in writing.

Designation Statement

I, _____, designate the following person(s) to be able to speak to a provider at Mikhail Novikov MD PC, or other staff member, should it be necessary, on my behalf. I hereby give permission to Mikhail Novikov MD PC through its physicians and staff to release to my designee(s) any information about my medical condition or medical needs or the status of my account and I release Mikhail Novikov MD PC its providers, and staff, from any claim of confidentiality in connections with the release of this information.

Name _____
Relationship_____
Copy of friend/family member driver's license/ID attached

Name _____
Relationship_____
Copy of friend/family member driver's license/ID attached

Patient's signature _____ Date: _____

Witness:_____