Patch Test Instructions

Your appointment schedule is as follows:

1. Day _____ Date_____ Time_____ (2-4 hours)
2. Day _____ Date_____ Time_____ (~30 minutes)
3. Day _____ Date_____ Time_____ (2-4 hours)

General Instructions Prior to testing, please watch our "patch test instructions" video on www.scheman.com which tells you what to expect during patch testing. Please allow 2-4 hours for the 1st and 3rd patch test visits and 30 minutes for the 2nd visit. **This includes possible waiting time.**

Prior To Patch Testing:

- **30 days prior to patch testing;** Stop cortisone injections. Stop direct sun exposure, tanning beds or medical light treatments on the back and thighs.
- **7 days prior to patch testing;** Stop all topical medications used on the back and thighs.
- **3 days prior to patch testing;** Stop all cortisone pills (never stop cortisone pills suddenly).
- **2 days prior to patch testing;** Stop all anti-histamines and NSAIDS (Motrin, Aleve, Naproxen…)
- **1 day prior to patch testing;** Stop all creams, ointments, lotions and etc. used on the back and thighs.

The Day of Patch Testing: Shower (or bathe) and wash your hair. Wear a comfortable, loose fitting T-shirt (or camisole and bra for women) which you will wear continuously for 2 days until your patches are removed. Buttoned shirts and jackets can be worn over these clothes if needed.

The First Two Days of Patch Testing: Your back will have patches that are held in place by paper tape. It is important that you avoid any bending, lifting, or twisting until the patches come off. Please keep in mind that if you have a young child or infant you will **not** be able to pick him/her up the first two days of patch testing and will need to arrange assistance.

During your 5 day Patch Test: The back must be kept dry, sweat free and not scratched. Limited sponge bathing but no showers are allowed during testing. You can wear deodorant.

Work/ Exercise/ School: You may need to be off of work or on light duty if your work requires using your back muscles or sweating. Exercise and sports activities are not allowed during testing. You will also not be able to carry a school backpack over your shoulders. Please let us know if you need a note for school or work.

Pregnancy/ Nursing: Please notify us if you are pregnant or nursing since only safe cosmetic ingredients will be able to be tested. Also keep in mind if you have an infant that you will **not** be able to pick them up for the first two days of patch testing.

Insurance: Please check with your medical insurance deductible and co-payment. By law, deductibles cannot be adjusted and will be your responsibility. You will also be responsible for your co-payment at *each visit.* Please make sure your insurance pays for code 95044 (the patch testing code).

If you suspect a particular item is causing your allergy; We can make custom extracts for many types of items for testing. An additionally fee of $100 will be charged per extract.
Questions: Please phone *Amy* (847)480-1111, prompt 1.

WHAT TO BRING TO YOUR FIRST VISIT:

1. **<u>You must bring in the original containers (if possible):</u>**
    a. All hair products (shampoos, conditioners, styling products, hair color)
    b. All skin care products (used anywhere on the body)
    c. All cosmetics
    d. All soaps and cleansers
    e. All hand cleansers from the kitchen, etc.
    f. All shaving products
    g. All antiperspirants, deodorants
    h. All nail care products
    i. All eye drops
    j. All topical medications

2. **<u>IF your LIPS are involved, also bring:</u>**
    a. Toothpaste
    b. Mouthwash
    c. Lip products

3. **<u>You DO NOT need to bring:</u>**
    a. Laundry products
    b. Household cleaning products
    c. Dishwashing products
    d. Oral medications

WHAT TO BRING TO YOUR SECOND VISIT:

1. The patches will be removed and outlined with purple surgical marker. You will want to bring a shirt that you don't care about since this marker can stain clothing.

CANCELLATION POLICY FOR PATCH TESTING 2022

Patch testing is a week of appointments. We usually have an extensive waitlist for this procedure. In an effort to accommodate all of our patients, we ask that you **must cancel** your appointment 3 DAYS PRIOR to your first test date.

- If your patch testing begins on a SATURDAY, you must cancel by Wednesday at noon.
- If your patch testing begins on a MONDAY, you must cancel by Thursday at noon.
- If you patch testing begins on a THURSDAY, you must cancel by Monday at noon.

If you cancel anytime not within the days given, a $350.00 cancellation fee will be charged.

Thank you for understanding,

Amy

Patch Supervisor

Patch Test Informed Consent

I understand that I (or my child) will be undergoing patch testing. The method of testing has been reviewed and I understand the purpose and need for testing. I understand that patches will be applied for 48 hours and will require visits to have results read on two different days. I understand that each visit will be billed to my insurance and co-pays will be collected at the time of each visit. During testing I have been instructed to keep the testing area dry, avoid exercise and excessive sweating.

Although patch testing is usually a very well tolerated procedure, there are rare side effects which you need to be aware of. You will often have itching during the procedure which typically is less after the patches are removed on day of your first patch test reading. Reactions occur typically at the site where the patch is applied and feel similar to an itchy insect bite. If you have a severe reaction, this may persist for a while after testing (in rare cases the reactions may persist for months) but will resolve over time. In some cases, a severe reaction will leave a temporary (or rarely permanent) change in skin color at the test site. Occasionally, the skin rash you were previously experiencing will get worse temporarily during testing. Systemic reactions (shortness of breath, throat swelling) do not typically occur with most allergens which cause contact allergy but there is an extremely remote chance this could occur.

I have read the above, fully understand the risks associated with patch testing and give permission to have this test performed by Dr. Andrew Scheman.

Signature: _____ Date: _____

Driving Directions

1535 Lake Cook Rd.
Suite 401
Northbrook, IL 60062

From I-294:

1. Exit Lake-Cook Road East (The office is approximately 3 miles east of I-294)

2. After the Metra viaduct, you will cross Waukegan Rd. (IL43). You will want to be in the right lane

3. At the 2nd stop light after Waukegan Rd. you will pass Citibank and turn right onto Northbrook Court Drive. A few feet ahead turn right again at the stop sign. The mall will be on your left.

4. Follow the drive around the mall to the back of the mall. Stay in the right lane. You will see a sign to your right that says "*Northbrook Court Professional Plaza Ahead"*. Then there is going to be another larger dark blue sign for the *1535 Professional Plaza* which is a group of 1 story buildings. Turn right into the main parking lot.

5. At the stop sign our office building (Suite #401) will be directly in front of you.

From US41/ Edens Expressway:

1. Exit Lake-Cook Road West. (The Botanic Garden is East which is the wrong direction)

2. You will cross Skokie Blvd and go under the railroad bridge. Turn left at Lee Rd.

3. Turn right onto Rudolph Dr. (first right) and continue on this road all the way around the mall (the mall will be on your right) Northbrook Court Drive will also be on your right.

4. Turn left when you the road ends. This is the 1535 Professional Plaza which is a group of 1 story buildings. Enter the main parking lot.

5. At the stop sign, our office building (#401) will be directly in front of you.

NORTH SHORE
MEDICAL AESTHETICS
CENTER FOR

RETURN PATIENTS: PLEASE ENTER ONLY INFORMATION WHICH HAS CHANGED SINCE YOUR LAST VISIT.

☐ **NONE OF THE INFORMATION BELOW HAS CHANGED SINCE MY LAST VISIT.**

PATIENT

NAME: _____ **DATE:** _____

ADDRESS: _____ _____ _____ _____
STREET CITY STATE ZIP

SEX: _____ **AGE:** _____ **DATE OF BIRTH:** _____ /_____ / _____

TELEPHONE: HOME: ( ) - _____ - _____ WORK: ( ) - _____ - _____ CELL: ( ) - _____ - _____

E-MAIL ADDRESS: _____ **OCCUPATION / POSITION:** _____

BUSINESS NAME: _____

BUSINESS ADDRESS_____ _____ _____ _____
STREET CITY STATE ZIP

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED / WIDOWER ☐ SEPARATED

SPOUSE INFORMATION: NAME: _____ OCCUPATION: _____ TEL: ( ) - _____ - _____

RESPONSIBLE PARTY

INSURED'S NAME: _____ **RELATIONSHIP TO PATIENT:** _____ **TEL**: ( ) - _____ - _____

SEX: _____ **DATE OF BIRTH:** _____ /_____ / _____

INSURED'S ADDRESS: _____ _____ _____ _____
STREET CITY STATE ZIP

INSURANCE INFORMATION (ONLY FILL OUT IF ASKED TO)

NAME OF INSURANCE COMPANY: _____

ID #: _____ **GROUP #:** _____ **POLICY #:** _____

REFERRED BY: _____

PRIVACY: I HAVE RECEIVED A COPY OF THE NSCMA NOTICE OF PRIVACY PRACTICES REGARDING PRIVACY OF MY MEDICAL RECORDS AND MEDICAL INFORMATION.

_____
SIGNATURE

PLEASE RETURN THIS COMPLETED FORM TO THE RECEPTIONIST. ALSO, PLEASE ATTACH YOUR INSURANCE CARD TO THE TOP OF THE CLIPBOARD. IT WILL BE RETURNED TO YOU AT OR BEFORE THE TIME OF CHECKOUT.

NORTH SHORE CENTER FOR MEDICAL AESTHETICS, LTD.

DR. ANDREW SCHEMAN ● DR. TODD JOHNSON
DR. SHERYL HOYER ● ELIZABETH COOK, P.A.

NORTHBROOK COURT PROFESSIONAL PLAZA ● 1535 LAKE COOK ROAD ● SUITE 401
NORTHBROOK, ILLINOIS 60062 ● TEL: (847) 480-1111 ● FAX: (847) 480-1131

History Intake Form

Patient Name: _____ **Date of Birth:** _____

Patient Medical History: Have you ever had any of the following:

Seasonal Allergies	Yes	No	Glaucoma	Yes	No	High Blood Pressure	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No	Pacemaker	Yes	No
Hay Fever	Yes	No	HIV/AIDS	Yes	No	Diabetes	Yes	No
						Tobacco Use	Yes	No

Patient Dermatologic History: Have you ever had any of the following:

Eczema	Yes	No	Melanoma	Yes	No
Childhood Eczema	Yes	No	Other Skin Cancer	Yes	No
Hives	Yes	No	Psoriasis	Yes	No
Keloids	Yes	No	Sun Burn (excessive)	Yes	No

Currently breastfeeding or pregnant? Yes No

Height _____ft _____in

Weight _____lbs

Family History: Has any blood relative ever had any of the following:

Seasonal Allergies	Yes	No	Eczema	Yes	No	Malignant Melanoma	Yes	No
Hives	Yes	No	Psoriasis	Yes	No	Other Skin Cancer	Yes	No
Asthma	Yes	No	Hay Fever	Yes	No	Acne	Yes	No

List any drug <u>allergies</u>: _____

Review of Systems: Do you have any current medical problems in the following areas

Allergies	Yes	No	Endocrine/Hormonal	Yes	No	Hematologic (bleeding)	Yes	No
Cardiovascular	Yes	No	Eyes	Yes	No	Lungs	Yes	No
Chills/Fever/Headache	Yes	No	Gastrointestinal	Yes	No	Musculoskeletal	Yes	No
Ear/Nose/Throat	Yes	No	Genital/Urinary	Yes	No	Neurologic/Psychiatric	Yes	No

If yes; name of condition: _____

Previous Skin Cancer surgery: _____**Any previous MAJOR surgeries:** _____

Skin Type (circle one)

(I) Always Burns; Never tans
(II) Can tan a little but gets red first
(III) Tans easily but can burn if gets too much sun
(IV) Tans easily. Doesn't burn usually
(V) Dark Caucasian or light African American
(VI) Dark African American

Medications/ Supplements	Dosage	Directions	Medications/ Supplements	Dosage	Directions

Topical Medications (creams, etc.)	Directions	Topical Medications (creams, etc.)	Directions

X_____ _____ _____

Signature of the patient or guardian | Date | Provider Initials

North Shore Center for Medical Aesthetics, Ltd.; Fees and Payment Policies

Fees; Thank you for choosing North Shore Center for Medical Aesthetics, Ltd. (NSCMA) as your dermatology provider. We always strive to treat you with courtesy and to provide the finest medical care. Changes in health care laws have made it essential to collect full payment for all services in timely manner in order to continue to provide the quality of care you have come to expect from us.

Payments due at time of service; Payment of copays are required at time of service prior to your appointment. All services not covered by insurance are also due at time of service. In addition, amounts due for deductibles and copayments in which the amount due can be determined are also due at time of service. We accept credit cards, debit cards, cash or checks.

Other payments; You will be required to provide a credit card number which we will store electronically encrypted to be used for forgotten payments, missed appointments and any amount your insurance company indicates is your responsibility on your explanation of benefits. You authorize NCSMA and our billing service (Physician Billing Solutions) to charge this credit card for these amounts due. You will receive a receipt for all payments.

Cancellation Policy; A cancellation fee will be charged for cancellations with less than 48 hour notice for surgery, less than 24 hour notice for other appointments and for missed appointments. For patch testing and MOHS, there is a $350 cancellation fee which will be charged unless appointment is cancelled at least 1 week prior. The cancellation fee will not be covered by insurance and you authorize us to bill your credit card for this fee unless an alternative, prompt means of payment is made.

Past Due Balances; For amounts less than 90 days past due, you may contact our billing office to determine if you qualify for Care Credit or other payment options to pay for past due amounts which are a hardship. If you have a balance due which is over 90 days past due, you will receive a notice giving you 30 days to pay the past due amount or to find care at another practice. If payment is not received during this 30 day period, you will not be able to receive care from our doctors until payment has been made. Amounts greater than 60 days past due may be subject to a late payment fee.

Insurance; Insurance claims will be submitted to your insurance as a courtesy, however, you are fully responsible for the amounts due which are not paid by your insurance. If we are not a provider in your insurance plan or if you do not have a referral which is required by your insurance, you will be responsible for full payment of all charges at the time of service.

I authorize NCSMA to provide dermatological services and agree to abide by the above policies.

Signature: _____ Date: _____