

**The Vascular Birthmarks Foundation**  
**Along with Dr. Roy Geronemus and The Laser & Skin Surgery Center of New York**  
**Present the 2010 Vascular Birthmarks Conference**  
**Saturday, October 9, 2010**

**Conference/Clinic Registration Form**

**Register now. Early registration ensures you a discounted hotel room and a clinic appointment.**

**Conference:** NYU, Farkas Auditorium, 550 First Avenue

Registration Check In: 7:30am

Conference Sessions: 8:30am - 1:00pm

**Clinic Sessions and Special Sessions:** Laser & Skin Surgery Center of New York, 317 East 34 Street

1:00pm - 6:00pm

**Section 1 – Contact Information**

Please note there are two categories for attendees. They include patients and their family/friends/guardians, and attending physicians

**Patient Information**

Conference/Clinic fee \$100 per family

Name of patient: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Name(s) of Parent or Guardian if patient is a child: \_\_\_\_\_  
\_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers (How can we best reach you?)

(home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Email: \_\_\_\_\_

Name of Patient's Physician \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please include names and ages of siblings, family members or friends who will be joining you and the patient at the conference. For adults, please mark *adult* where it requests age.

Name \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Name \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

**Attending Physician Information - (This includes those who are speaking, administering clinic appointments, or attending for CME credits.)**

Physician's conference fee is \$100.00. Will you be requesting CME credits? \_\_\_\_\_yes \_\_\_\_\_no

Name of Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone Numbers (How can we best reach you?)

(home) \_\_\_\_\_(work) \_\_\_\_\_(cell) \_\_\_\_\_

(email) \_\_\_\_\_

Please include names and ages of family members, friends or associates who will be joining you. For adults, please mark *adult* where it requests age.

Name \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Physician: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relation to Physician \_\_\_\_\_

**Section 2 – Lodging and Meals**

The first 50 families that register will have meals included and FREE lodging for Friday night and a reduced rate of \$269 plus tax and incidentals per night for any additional night(s). Lodging will be at The Affinia Dumont or The Affinia Shelburne in New York City.

In order to guarantee a room, call Basia Joyce at 518-495-3938, she will make hotel reservations for your party.

**PLEASE REQUEST YOUR RESERVATION AS SOON AS POSSIBLE TO ENSURE THIS OFFER.**

**The Continental breakfast and box lunch are provided to all conference attendees free of charge.**

Will you be attending the continental breakfast on Saturday morning \_\_ Yes \_\_ No.

# of adults \_\_\_\_\_aged 13 and up

# of children \_\_\_\_\_13 and under

Will you have box lunch on Saturday \_\_ Yes \_\_ No.

# of adults \_\_\_\_\_aged 13 and up # \_\_\_\_\_Regular # \_\_\_\_\_Vegetarian

# of children \_\_\_\_\_13 and under. # \_\_\_\_\_Regular # \_\_\_\_\_Vegetarian

**Section 3 - Clinic Registration/Information**

Clinic appointments will be on Saturday, October 9, from 1pm-6pm. The clinic appointments will be held at the Laser & Skin Surgery Center of New York, 317 East 34 Street, New York, NY 10016

If you would like a clinic appointment, please complete the following:

\_\_\_ Yes, I would like a clinic appointment. If possible, I would like an appointment at: \_\_\_\_\_ (approximate time). Clinic appointments will begin at 1pm with the last one scheduled to begin at 5:30 pm. There will be 4 clinic teams that are listed below. Clinic appointments last about 15 minutes.

For those of you with travel constraints, please write below what time you need to be seen by in order to give you time to get to the airport or make other travel requirements: \_\_\_\_\_

Please mark information below regarding clinic team.

**Physicians: Please indicate the team on which you would like to work.**

**Families: Please indicate which team you would like to be seen by.**

**Note: For Clinic appointment, please include a photo of the patient clearly showing the birthmark with this registration form. If you have any films, MRIs, Xrays or Scans, please bring them to the clinic appointment, along with photos that document the history of the birthmark. Do not mail imaging studies to VBF.**

**Clinic Teams:**

**Place X next to team**

- |   |     |   |
|---|-----|---|
| 1. Hemangioma                                   | ___ | Levitin/Blei/Darrow/Orlow               |
| 2. PWS  | ___ | Mihm/Nelson/Geronemus/Duarte/Rabinowitz |
| 3. Malformations & Syndromes of the Head & Neck | ___ | Zide/Comi/Westra/Guntau                 |
| 4. Malformations & Syndromes of the Extremities | ___ | Rosen/Delfanian/Konez                   |

If you are unsure of your team preference, but would like to see a particular physician, please write his or her name below:

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Do you or anyone coming to the conference require special needs? This includes travel schedule constraints or health concerns or disabilities that require attention.

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Briefly describe the birthmark. Include location and any treatment(s) to date.

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## Section 4 - Daycare Services

Daycare services will be provided free of charge during the Saturday morning conference lecture from 8:30am to 12:30pm

Will you need daycare services?  Yes  No.

Names and ages of children:

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## Section 5 – Special Sessions: Make-up, Patient & Family Discussion Sessions, Psychotherapy, and Insurance/Legal Sessions

Please indicate the number attending each session after Yes#.

Make-up Session: Yes #\_\_\_\_\_ No\_\_\_\_\_

Patient and Family Discussion Session: Yes #\_\_\_\_\_ No\_\_\_\_\_

Insurance/Legal Assistance Session: Yes #\_\_\_\_\_ No\_\_\_\_\_

Psychotherapy Session: Yes #\_\_\_\_\_ No\_\_\_\_\_

Teen Group Discussion: Yes #\_\_\_\_\_ No\_\_\_\_\_

Orthodontic Exam: Yes #\_\_\_\_\_ No\_\_\_\_\_

Microskin New York: Yes #\_\_\_\_\_ No\_\_\_\_\_

Parent Roundtable Discussion: Yes #\_\_\_\_\_ No\_\_\_\_\_

Support Groups (KTS/SWS/LM/VBF): Yes #\_\_\_\_\_ Support Group\_\_\_\_\_ No\_\_\_\_\_

If you require more information on these, please call Basia Joyce at 518-495-3938.

Sessions will take place 1:00pm to 6:00pm.

## Section 6 - Registration Fees

**Registration Fee** is \$100.00 per family for the Conference/Clinic. **If you must cancel see Section 7 for Refund Policy.**

Credit card type:  M/C  Visa  Discovery  American Express

Credit card number: \_\_\_\_\_ Date of Expiration\_\_\_\_\_

Name as it appears on credit card \_\_\_\_\_ Amount:\_\_\_\_\_

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

*Note: All credit card transactions require full payment of \$100. If you are unable to pay fees due to financial hardship, check and sign below. Those fees will be waived; however, a credit card is still required to secure your room. See Section 7 Refund Policy for details.*

### Hardship Waiver:

Please check below if you cannot afford to pay the balance of the clinic fees and sign your name:

\_\_\_\_ (I request waiver of the remaining fee) \_\_\_\_\_ Signature\_\_\_\_\_ Date

## Section 7 Refund Policy

Credit Card information is required to reserve your room. If you cancel on or before September 24, 2010 your full registration fee is refundable. If you cancel after September 24, 2010, but on or before October 1, 2010 you are eligible for a 50% refund. Cancellations after October 1, 2010 are non-refundable. There will be no refunds for anyone who cancels after that date.

Families who have a financial hardship can ask for a waiver of fees. A credit card will still be required from these families. If you receive a free hotel room and do not check in for the Conference, but still use the free room, your card will be charged at a rate of no less than \$269 plus tax per night. You must attend the Conference to receive a free room. Please check-in at the Conference Registration Table to ensure that you are confirmed. If you reserve a free room but don't show, your card will be charged.

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**Total Amount enclosed:** \$\_\_\_\_\_.

Thank You. You will receive a confirmation of your registration. Please keep the confirmation letter for admission to the conference.

Please send registration form and fee as soon as possible to:

Vascular Birthmarks Foundation  
P.O. Box 106  
Latham, NY 12210

For more information or if you have any questions, contact Basia Joyce, VBF Executive Assistant at [BasiaJim99@nycap.rr.com](mailto:BasiaJim99@nycap.rr.com) or call 518-495-3938.

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**NOTE: PLEASE MAKE A COPY FOR YOUR RECORDS**