PATIENT'S INFORMATION

Date _____

E-mail Address _____

Patient's Name _____ Spouse _____

Address: _____ Apt. # _____

City _____ State _____ Zip _____

Home (____) _____ Cell Ph: (____) _____ Birth Date _____ Age _____

Social Security # _____ Drivers License # _____ Sex (Male/Female)

Family Doctor _____ Phone (____) _____

Emergency Contact _____ Phone (____) _____

Patient's Employer _____ Occupation _____

Address _____ Work Phone (____) _____

City _____ State _____ Zip _____

How were you referred to this office? _____

MEDICARE EPO/PPO HMO PRIVATE CASH CO-PAY _____

PRIMARY INSURANCE INFORMATION

Insurance Co. Name _____ Group/Policy # _____

Insurance Address: _____ I.D # _____

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

Insured's Address: _____

Insured's Social Security # _____

Patient relationship to insured: Self Spouse Child

Please complete the following if insured is other than self.

Insured's Employer: _____ Occupation: _____

Address: _____ Work Phone: (____) _____

City: _____ State _____ Zip _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name _____ Group/Policy # _____

Insurance Address: _____

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

Insured's Address: _____

Insured's Social Security # _____

Patient relationship to insured: Self Spouse Child

Please complete the following if insured is other than self.

Insured's Employer: _____ Occupation: _____

Address: _____ Work Phone: (____) _____

City: _____ State _____ Zip _____

AUTHORIZATION OF MEDICAL BENEFITS

I hereby authorize the _____ **Insurance company to pay by check or mail to:** Integrated Dermatology & Dermatopathology, Inc.
3325 Palo Verde Avenue, Suite 107
Long Beach, CA 90808

The medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assigned and I have agreed to pay, in a current manner, and balance of said professional service charges over and above this insurance payment.

I further authorize the release of any medical information necessary to process this claim.

Signed: _____

Integrated Dermatology & Dermatopathology, Inc.

3325 Palo Verde Ave., Ste. 107
Long Beach, Ca 90808
(562) 420-8333

MEDICAL HISTORY

Patient: _____ Date: _____
Last First Middle

SEX: M F

Reason for today's visit: _____

_____

Are you allergic to any medications? ☐ YES ☐ NO If YES, list:

1. _____ 3. _____
2. _____ 4. _____

List all medications you are currently taking (include "over the counter" medication and nutritional supplements):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO
LUNGS:		
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic cough	☐	☐
Nasal Allergies	☐	☐
CARDIOVASCULAR:		
High blood pressure	☐	☐
Chest pain	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Irregular heart beat	☐	☐
Pace maker	☐	☐
Phlebitis	☐	☐
OTHER SYSTEMIC:		
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Stomach	☐	☐
Bowel	☐	☐
Hepatitis/Jaundice	☐	☐
Arthritis	☐	☐
Glaucoma	☐	☐
Fainting	☐	☐
Convulsions, epilepsy or seizures	☐	☐
Blood/Lymph Disorders	☐	☐

MEDICAL HISTORY
(Continued)

Patient: _____ Date: _____
Last First Middle

	YES	NO	
Do you drink alcohol?	☐	☐	If YES, how many drinks per day? _____
Do you use IV drugs?	☐	☐	If YES, what? _____ How often? _____

Have you ever had local or dental anesthesia (Novacaine, Lidocaine, Xylocaine)? ☐ YES ☐ NO

Any bad reaction? ☐ YES ☐ NO

Please answer the following questions:

Do you smoke?	☐ YES	☐ NO	If YES, how much? _____
Do you bleed easily?	☐ YES	☐ NO	
(Women) Are you pregnant?	☐ YES	☐ NO	Due date: _____
Do you have artificial joints?	☐ YES	☐ NO	

What is your occupation? _____

What are your hobbies? _____

Have you traveled in the last 6 months? ☐ YES ☐ NO If YES, where? _____

SKIN:

When you are exposed to the sun do you	☐ Tan only	☐ Burn, then tan	☐ Burn	
Have you ever had skin cancer?	☐ YES	☐ NO		
Have you ever had a melanoma?	☐ YES	☐ NO		
Has any family member had skin cancer?	☐ YES	☐ NO	If YES, whom? _____	
Has any family member had a melanoma?	☐ YES	☐ NO	If YES, whom? _____	
Do you get cold sores or fever blisters?	☐ YES	☐ NO		

List any history of past or present skin disorders:

1. _____
2. _____
3. _____
4. _____

Completed by: ☐ Patient
☐ Medical Assistant _____
Initials

_____ _____
Patient Date

_____ _____
Physician Date

Integrated Dermatology & Dermatopathology Inc.
3325 Palo Verde Ave., Ste. 107
Long Beach, Ca 90808
Phone (562) 420-8333 Fax (562) 420-8433

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative location.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 10, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

Integrated Dermatology & Dermatopathology, Inc.

3325 Palo Verde Ave., Ste. 107
Long Beach, Ca 90808
(562) 420-8333

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Integrated Dermatology & Dermatopathology, Inc. I hereby acknowledge receipt of Integrated Dermatology & Dermatopathology, Inc.'s Notice of Privacy Practices.

Patient Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Integrated Dermatology & Dermatopathology Inc.'s Notice of Privacy Practices with respect to the patient.

Patient name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

Integrated Dermatology & Dermatopathology Inc.
3325 Palo Verde Ave., Ste. 107
Long Beach, Ca 90808
(562) 420-8333

I, _____,
hereby state that my lab/test results may be given to any of the following:

(Please check all that apply, and **list names/phone numbers** as appropriate)

- o Answer machine at phone number _____
- o Spouse _____
- o Mother _____
- o Father _____
- o Sister(s) _____
- o Brother(s) _____
- o Son(s) _____
- o Daughter(s) _____
- o Caregiver _____
- o Other _____

- o NO ONE ELSE BUT PATIENT

Patient signature: _____

Date: _____

Integrated Dermatology & Dermatopathology Inc.

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Thank you for choosing Integrated Dermatology & Dermatopathology, Inc. We are committed to the success of your treatment. We hope you understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to read, agree to, and sign, prior to any treatment. This financial policy applies to all services rendered by all the doctors.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any co-pay/co-insurance amount due at the time services are rendered. For patients with dual insurance coverage, we will bill both the primary and secondary insurance if you have provided us with the necessary information.

An administrative fee of $75.00 will be charged for any surgical procedures (which extra time is allotted) cancelled without a 24 hour notice. We would appreciate a 24 hour notice of cancellation for routine office visits. We MAY charge $15.00 fee for missed office visits.

For services outside the office, there will be a separate charge from the facility where the services are rendered. (e.g. laboratory, pathology-biopsy interpretation).

We accept all major credit cards, cash and checks. If you have any questions regarding this policy, please contact Anna Perez.

"I have read, understand and agree to the provisions of this policy."

_____ _____

(Signature patient/guarantor) (Date)

_____

(Print name)