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center for advanced DERMATOLOGY inc.

Dermatology Medical History

Patient: ______________________ Date of Birth:_____/_______/_______ Today's date:_____/_______/_______

Reason for today's visit:____

Are you allergic to any medication? ☐ Yes ☐ No If yes, list below:

1.______________________________ 2.______________________________

Have you ever had dental anesthesia (Novocain)? ☐ Yes ☐ No Any bad reaction? ☐ Yes ☐ No

List all medications you are currently taking (including prescriptions, over-the-counter meds; and herbals):

1.______________ 3.______________ 5.______________

2.______________ 4.______________ 6.______________

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

Lungs	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Excessive Thirst/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal	☐	☐
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea When taking antibiotics	☐	☐
Yeast infection when Taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Fainting	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐

List any other diseases or conditions: ______________________________

List surgical procedures you have had in the last 6 months:______________________________

Have you ever had skin cancer ☐ YES ☐ NO

Has anyone in your family had skin cancer ☐ YES ☐ NO

Do you have a history of any specific skin diseases ☐ YES ☐ NO If yes,______________

Do you have problems with healing ☐ YES ☐ NO

Do you develop keloids (scars) after surgery ☐ YES ☐ NO

Do you bleed easily? ☐ YES ☐ NO

Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin ☐ Other______________________________

Social History:

Do you drink alcohol ☐ YES ☐ NO If YES ______________drinks per day

Do you use IV drugs ☐ YES ☐ NO If YES, What______________How Often?______________

Do you smoke ☐ YES ☐ NO If YES, how much:______________

Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

Please answer the following questions:

(Women) Are you pregnant? ☐ YES ☐ NO Due Date:_/_______/_______

What is your occupation?______________________ Hobbies:______________________

Completed by: ☐ Patient ☐ Medical Assistant ___________ Initials

______________________ Signed by Patient _______/_______/_______ Date

______________________ Reviewed by _______/_______/_______ Date

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OFFICE & FINANCIAL POLICIES

Welcome and thank you for choosing Dermatology Arts/ Center for Advanced Dermatology for your dermatology care. We are committed to the highest professional standards of skin care while providing patients with a comfortable and friendly environment. We hope that by providing you with our policies in advance we can prevent any misunderstandings during your time with us.

Initial_______ Insurance: When making an appointment, it is your responsibility to confirm with your insurance company (or companies if you have a secondary policy) that the physician is currently under contract with your plan. Each plan has its own stipulations regarding the coverage of, and payment for, medical services; therefore it is your responsibility to know your plan's benefit policies including co-payments, prior to your appointment. Ultimately all insurance deductibles, co-payments, and denials for primary or secondary insurance policies will be your financial responsibility.

Initial_______ Co pays/Outstanding Balances: Please be prepared to pay any past balances on your account. Payment of co-pays and non-covered services will be required at time of service. For your convenience, we accept cash, checks for amounts under $500, MasterCard, Visa, and Discover card.

Initial_______ Out-of-Network: If your insurance is with a company that our office does not contract with, you must pay for your services at the time of service.

Initial_______ Medicare/Medical Patients Only: We are not under contract with Medical; therefore whatever Medicare does not cover will be the financial responsibility of the patient.

Initial_______ Check-in: We do our best to keep on schedule, so please arrive for your appointment on time. If you arrive more than **20 minutes past** your scheduled appointment time, you will be rescheduled so that other patients are not inconvenienced. Please bring your current insurance card(s) with you to your first visit. On subsequent visits, it will be your responsibility to notify us of any changes in your address and/or insurance information; otherwise, you will be responsible for any omissions, financial or otherwise, related to these changes.

Initial_______ Non-covered Services: If you are coming for a non-covered service, please be prepared to pay for the service in full at the time of service. Cosmetic procedures including, but not limited to, sclerotherapy, Botox, laser procedures, hair reduction, photo rejuvenation, chemical peels, dermabrasion and fillers are not covered by insurance and claims will not be filed for them.

Initial_______ Refunds/Exchanges: Partial refunds for incompletely used cosmetic packages may be given within 30 days of purchase. No refunds will be given after 30 days; however, any unused balance may be applied towards other services and/or products. Products may be returned for a full refund within 30 days of purchase if unopened and in their original packaging.

Initial_______ NO SHOWS and Late Cancellations: We require a **24-hour advance notice** if you must cancel your appointment. Any **NO SHOW** or **late cancellation** will result in **a $75** charge.

Initial_______ Minors: The parent(s) or guardian(s) must accompany a minor for their first visit to our office, and are responsible for providing current insurance information and/or payment in full for services provided. For follow-up visits, unaccompanied minors must have an authorization note for medical treatment signed by a parent or guardian before treatment can be rendered.

Initial_______ providing proper documentation: In order to protect patient's privacy, for proper treatment, for proper medication, for insurance purposes and to release any medical records, you will be required to provide a photo ID to copy and to keep in your medical records.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information as necessary for insurance filing and precertification by signing this statement.

____DOB:______________________
Patient Signature (if minor, parent signature)

____Date:_____________________
Patient Name

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NOTICE OF PRIVACY PRACTICES

HIPAA, the Health Insurance Portability Act of 1996 had recently been formalized and will help govern the relationship between patients and their providers of Health Care to provide all entitled Medical Services in the most efficient way

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU, AS THE PATIENT, MAY GET ACCESS TO THIS INFORMATION

Please Read and Review Carefully

If you have any question about this notice, please contact our office directly.

We appreciate the trust that patients place in us and we recognize the importance of protection the confidentiality of non-public personal information that we have in our possession. This information will be used only to ensure accuracy in carrying out treatments for you and in keeping your records. In transactions with patient's health carriers or affiliates they designate, we will always endeavor to use information that is absolutely necessary to comply. If we change this policy, we will notify you in advance.

This notice describes the information privacy practices that are followed by our employees, physicians and all other office personnel.

HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care/services you receive at this office. It also reviews the ways in which your health information may be disclosed to other entities and it describes your rights and our obligations in managing the privacy and integrity of your care. We are required by law to give you this notice and to help you understand its intent. **You must signify your understanding and agreement by signing in the appropriate spaces.** You may opt out of this agreement at any time by presenting this office with written notice of your wishes.

Patient or Guardian Signature	Date
Print Name	Date of Birth
Witness	Date

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PATIENT INFORMATION

As of _______________mm/dd/yy

(Please Print Legibly & Fill In or Correct All Fields)

PATIENT'S NAME: (F) _________________________ (M) _________________________ (L) _____________________

BIRTHDATE: ____________________ AGE: _______________ SOCIAL SECURITY #: ___________________________

ADDRESS: ___________________________________ CITY: ____________________________ ZIP: ____________

HOME: (_____) _______________________________ CELL PHONE: (____) ______________________________

EMAIL ADDRESS: ____

REFERRED BY:

☐ REFERRED BY PATIENT: _______________________________ ☐ REFERRED BY OTHER: __________________

☐ REFERRED BY DOCTOR: _______________________________ DOCTOR'S PHONE: (_____) ____________________

PRIMARY CARE PROVIDER: _____________________________ DOCTOR'S PHONE: (_____) ____________________

INSURANCE INFORMATION:

PRIMARY INSURANCE NAME: _________________________________ MEMBER ID: ___________________________

EMERGENCY CONTACT:

NAME: ____ RELATION TO PATIENT: ______________________________

PHONE: (______) _________________________________

☐**YES** ☐**NO (DO NOT)** I GIVE PERMISSION FOR *DERMATOLOGY ARTS/CENTER FOR ADVANCED DERMATOLOGY* TO RELEASE INFORMATION REGARDING MY APPOINTMENTS, MEDICAL FINDINGS, LAB REPORTS, ETC. *IF **YES***, PLEASE PRINT THE NAME OF THE PERSON(S) YOU WISH THIS INFORMATION BE RELEASED TO:
NAME: ____ RELATION: ____

☐**YES** ☐**NO (DO NOT)** I GIVE PERMISSION FOR *DERMATOLOGY ARTS/CENTER FOR ADVANCED DERMATOLOGY* TO LEAVE VOICEMAIL MESSAGES REGARDING MY APPOINTMENTS, MEDICAL FINDINGS, LAB REPORTS, ETC.

IF YES, PHONE # YOU WOULD LIKE US TO USE: (______) ____

PHARMACY INFORMATION:

PHARMACY NAME: ________________________PHONE#: (_____) ________________FAX #: (_____) ________________
*** PLEASE PROVIDE THE FAX NUMBER FOR YOUR PHARMACY

PATIENT'S SIGNATURE: __________________________________ DATE: _____________________________

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services ____________________

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ____________________ __________

Physician's or Authorized Representative's Signature (Date)

____

Print or Stamp Name of Physician, Medical Group, or Association Name

By: ____________________ __________

Patient's or Patient Representative's Signature (Date)

By: ____________________

Print Patient's Name

____

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

FOR VIEWING ONLY

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Cosmetic Interest Questionnaire

Patient Name: ________________________________ **Date:** ________________

General appearance or products of interest to you

(Please check all that apply)

- ☐ Skin care Products
- ☐ Filler
- ☐ Botox®
- ☐ Facial fine Lines
- ☐ Facial wrinkles
- ☐ Facial folds
- ☐ Thin Lips
- ☐ Blotchy Skin
- ☐ Facial veins
- ☐ Facial redness
- ☐ Liver spots/age spots
- ☐ Birthmark
- ☐ Tattoo removal
- ☐ Drooping eyelids
- ☐ Inadequate eye lashes/ Latisse®
- ☐ Facial Fullness
- ☐ Neck
- ☐ Legs veins
- ☐ Nose
- ☐ Other: ______________________

Have you had any cosmetic procedures in the past, for ex. Botox, fillers, chemical peels...?
Yes / No, If yes list procedure: ____
Were you happy with the outcome? **Yes / No**
If NO, why? ____

Are you interested in receiving our e-newsletter? Our newsletter will inform you of any news within our practice as well as any promotions we may be offering. **Yes / No**
If yes please provide us with your email.

Email address: (please print) ____

Patient Signature:________________________________ **Date:**_______________