NEWPORT COAST DERMATOLOGY
PATIENT REGISTRATION FORM

Account Number: _____

E-Mail_____

PATIENT INFORMATION

Name: _____ DOB: ____/____/____ Age: _____ Sex: M / F
First Middle Last

Home Address: _____
Street City State Zip

Work Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____-_____-_____ Driver's Lic: _____ Occupation: _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Name: _____SSN_____

Address: _____DOB: _____/_____/_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AND DRIVER'S LIC. AT TIME OF CHECK-IN)

Insurance Name: _____

Insurance Address: _____

Name of Insured: _____ Insured ID #_____ Group #_____

Insured's SSN#_____-_____-_____ DOB_____/_____/_____ Relationship to Insured: _____

In Emergency, Who May We Contact?

Name: _____ Relationship: _____Phone:_____

Address: _____

Referred By: _____

Preferred Pharmacy: _____ Phone: _____

Do we have your permission to:	Leave a message on your answering machine at home?	☐ Yes ☐ No
	Leave a message at your place of employment?	☐ Yes ☐ No
	Discuss your medical condition with family?	☐ Yes ☐ No

Do you have dental insurance? ☐ Yes ☐ No PPO? ☐ Yes ☐ No Name of Insurance: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I hereby assign my insurance benefits to be made directly to my physician for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company.

Patient or Responsible Party Signature: _____ **Date:** _____

Newport Coast Dermatology Medical History

Patient Name: _____ **Date**: _____

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

_____

Have you ever had dental anesthesia? ☐ Yes ☐ No Any bad reaction? ☐ Yes ☐ No
Date of last dental exam: _____

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

_____

_____

Do you take any blood thinners like aspirin, coumadin, plavix, motrin, Vitamin E? ☐ Yes ☐ No

Do you have or have you ever had any diseases or conditions of: (Please Check YES or NO)

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Diabetes	☐	☐
Heart Attack/Angina	☐	☐	Thyroid Disease	☐	☐
Heart Murmur	☐	☐	Urinary Disease	☐	☐
Pacemaker	☐	☐	Stomach Ulcers	☐	☐
Anxiety	☐	☐	Hepatitis	☐	☐
Mitral Valve Prolapse	☐	☐	Dialysis	☐	☐
AIDS/HIV	☐	☐	Arthritis	☐	☐
Artificial Valves	☐	☐	Artificial Joints	☐	☐
Asthma	☐	☐	Fainting	☐	☐
Shortness of Breath	☐	☐	Seizures	☐	☐
Tuberculosis	☐	☐	Stroke	☐	☐
Blood Clots	☐	☐	Migraines	☐	☐
Sinus Allergies	☐	☐	Depression	☐	☐
Cancer: Type? _____	☐	☐			

List any other conditions: _____

List any major surgeries: _____

(Women) Are you currently pregnant or nursing? ☐ Yes ☐ No

Have you ever had any skin cancer? ☐ Yes ☐ No explain: _____

Has any blood relative had any skin cancer? ☐ Yes ☐ No explain: _____

Do you have a history of any skin diseases? ☐ Yes ☐ No explain: _____

Do you have any problems with healing? ☐ Yes ☐ No explain: _____

Do you keloid or scar easily? ☐ Yes ☐ No explain: _____

SOCIAL HISTORY:

Do you drink alcohol?☐ Yes ☐ No If Yes_____ drinks per ☐ day ☐ week

Do you use IV drugs? ☐ Yes ☐ No If Yes, what? _____

Do you smoke? ☐ Yes ☐ No If Yes, how much: _____

Have you had or been exposed to HIV/ AIDS? ☐ Yes ☐ No

What is your current occupation? _____
What are your current hobbies? _____

Completed by ☐ **Patient Signature:** _____ **Date**: _____

☐ Medical Assistant _____ Reviewed By: _____ Date: _____
Initials

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy of contacting our office.

You have the right to request that we restrict how protected health information about you is used for disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

I understand that:

The Practice has permission to call or contact and/or their responsible financial guarantor for treatment, payment, or health care operations. The Practice Policies include generally confirming patient appointments via phone or leaving messages on voicemail or answering machines. The Practices may call or contact patients for test, biopsy, other lab results, follow-ups, and visit reminders. In case of medical emergency or need for urgent contact, listed patient emergency contacts may be contacted. To ensure safety of patients and staff, the Practice has a 24 hour security system and premises video monitoring system and policy in place.

This Consent was signed by: _____
Print Name – Patient or Representative

_____ ____/____/____
Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____ ____/____/____
Staff signature Date

Newport coast dermatology patient financial policy and signature on file

We understand that you have a choice in healthcare and we thank you for choosing us to serve you and your family's skin care needs. We are committed to providing you with the best possible care, and we are pleased to discuss professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility. You may ask for an estimate of your charges before a procedure is performed. Please note that all procedures have additional costs and are not included in a regular office visit fee. (Freezing, "burning-off", skin tag removal, laser, acne surgery/slush, peels, biopsies, surgeries, injections, cyst drainage, mole or wart removal, etc.)

INSURANCE (Please check with your carrier before your visit to confirm coverage.) I understand that it is my responsibility to know my insurance plan and to verify coverage for referrals to other doctors, recommended tests and laboratories. I understand that there are numerous insurance companies, even more individual health plans and very variable benefits. My doctor's office does not know my individual plan and is not authorized to make any guarantees regarding individual insurance coverage.

PPO INSURANCE: **We are providers of most PPO plans**. Newport Coast Dermatology has preferred provider contracts with several insurances including Blue Cross, Blue Shield, Aetna, Pacificare, Cigna, United Healthcare, HealthNet, PHCS, CCN, and Beechstreet. One insurance carrier is billed in courtesy for me. I may choose to self-bill any secondary insurance plans. (EPO plans require a credit card guarantee.)

MEDICARE: **We accept straight Medicare (NO HMOS OR RAILROAD MEDICARE). Please note Federal Law mandates Medicare's annual $165 deductible**.

MEDI-CAL/CAL-OPTIMA: **We are NOT providers of any state plans nor can we accept anyone with Medi-Cal.**

HMO INSURANCE/MONARCH HMO: **We do not have any HMO contracts**. . If you should decide to be seen outside of your plan, your visit will be considered self-pay and full payment for all services is due at the time of your visit.

CO-PAYS: I understand that insurance plans legally and contractually obligate all health care providers to collect my set co-pay at each and every visit. (Please note and be prepared to pay your co-pay due at check-in, before your visit.)

DEDUCTIBLES & CO-INSURANCE: We will bill your insurance carrier but you will receive a statement from us regarding any deductibles or co-insurance that your insurance company has deemed your responsibility as designated on your explanation of benefits.

LAB TEST AND PATHOLOGY CHARGES: If my visit includes biopsies, lab tests, or cultures, I understand that I will receive separate billings from the company performing these outside services for me. All biopsies and surgeries result in a specimen being sent to pathology for examination, and therefore will be additional charges. If any pathology specimen requires a second opinion, the consulting lab will bill your insurance separately.

UNPAID ACCOUNTS: Accounts not cleared in a timely fashion will accrue a minimal late fee of $15 per unpaid statement cycle/month. Unpaid accounts in bad standing are sent to collections which will result in further costs including late fees, collections fees, legal fees, and may cause an adverse incident on my credit report. Returned bad checks require a $35 fee. Unpaid bad checks are referred to The Orange County District Attorney for legal remedy.

COSMETIC SERVICES: Facial peels, lasers, collagen, Restylane, and Botox injections are among the many cosmetic/insurance NON-covered services. These are strictly self-pay/cash basis and are paid immediately at the time of the procedure. Newport Coast Dermatology is not permitted to bill any cosmetic services to patients or insurance.

SPECIAL NOTE: I understand that insurance is a special contract between me and my insurance company. I understand that Newport Coast Dermatology is not a party to this contract and has no authority to become involved in insurance carrier disputes other than to supply factual information as necessary. I understand that if my insurance is not effective, if my insurance refuses coverage for what they deem "not medically necessary", or if my insurance demands a refund on a previously paid claim, I will need to pay for all medical services performed. I understand that I am always ultimately responsible for medical services which I choose to receive, and the timely payment of my account. I have read and understand the above information.

Patient or Responsible Party Signature: _____ Date: _____

PAYMENT POLICY:

Medicare: We are participating providers of straight Medicare **BUT NOT HMOS OR RAILROAD MEDICARE**. We will accept assignment on all claims. Patients are responsible for meeting their annual $135.00 deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed the balance.

PPO: You will be responsible for paying your annual deductible if not met and co-payments at time of service.

COMMERCIAL PATIENTS: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 100% of the total bill at the time of the service. We will give you a copy of your bill to submit to your insurance for reimbursement.

Patient or Responsible Party Signature: _____ Date: _____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card: _____ Date: _____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file. I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Medigap Card: _____ Date: _____

NEWPORT COAST DERMATOLOGY

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to Newport Coast Dermatology. We intend to provide you with the care and service that you expect and deserve. Achieving your ***best possible health*** requires a "partnership" between you and your doctor. As our "partner in health," we ask you to help us in the following way:

• Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings.
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

• Keep Follow-up Appointments and Reschedule Missed Appointments
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

• Communication with the Office and Patient Privacy Agreement
To ensure patient HIPAA privacy laws and optimal speedy communication, I agree to communicate any questions or concerns via phone, secure fax, or in writing. I agree to the mutual privacy agreement and authorize the office to retain full copyrights to any communication or online posts related to my treatment and services.

• Call the Office When I Do Not Hear the Results of Labs and Other Tests
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

• Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and test, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

• I agree not to share any prescriptions written by any practitioners in this office with other people.
I understand that all prescriptions are written specifically for my medical condition and should not be shared with other people since they have not been medically evaluated for possible side-effects or drug interactions.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____ _____

Patient Signature Date