WELCOME! THANK YOU FOR COMING IN TODAY! REGISTRATION FORM

PLEASE **PRINT** and COMPLETE **ALL** SECTIONS

LAST Name	Check one: ☐**Mr.** ☐**Mrs.** ☐ **Ms.** ☐ **Dr.** ☐Miss ☐Pastor ☐Rabbi ☐Reverend ☐Officer ☐Judge
FIRST Name	Middle Name
ADDRESS	
CITY / STATE / **ZIP CODE**	
Cell Phone ( )	Work Telephone ( )
Home Telephone ( )	Email
Employer	Occupation
Status ☐Single ☐Married ☐Divorced ☐Widowed	☐Child /Teen (MUST BE WITH LEGAL GUARDIAN)
*Date of Birth / Age / Sex ☐ M ☐ F	
*Social Security #	
Check One: ☐PPO Insurance ☐Medicare ☐Self-Pay No Insurance ☐HMO(selfpay) ☐EPO (selfpay)	
*Whose NAME is policy under?: (*Insured Individual Subscriber)	
*Relationship of patient to main insured subscriber ☐ Self ☐ child ☐ Spouse ☐ Other	
*INSURED SUBSCRIBER SOCIAL SECURITY# / SUBSCR. BIRTHDATE	
*Emergency Contact (NOT living with you) Name & Phone:	
Your Pharmacy: (name, location & phone)	
Whom may we thank for your **REFERRAL**? (please list Name referring **DOCTOR,** friend, internet, etc) ☐DOCTOR: Dr. ☐Friend: ☐Family: ☐Internet	
Reason for Today's Visit:	

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. MEDICARE PATIENTS ONLY: I understand that Medicare requires my signature on file authorizing my doctor to file claims for me and to release information to Medicare if they require it for proper processing of a claim. I authorize release of all information to the Social Security Administration and Health Care financing Administration or its intermediaries for related medical claims. I authorize the assignment of medical service payments directly to my doctor's office. MEDIGAP ONLY: I authorize Medigap benefits to be made directly to my doctor's office for my medical care and release of any information required.

PLEASE PRESENT INSURANCE CARD & DRIVER'S LICENSE TO THE RECEPTIONIST FOR COPIES TO BE MADE.

KINDLY SUBMIT CO-PAYS, DEDUCTIBLES, AND CO-INSURANCE AT CHECK-IN*

.X _____ _____

SIGNATURE (OF PATIENT IF >18 OR RESPONSIBLE ADULT) **DATE** **STAFF** **1**

. ****TOP*** PLACE ON LEFT SIDE OF CHART TOP SHEET

Dear Patient,

Our Healthy Patient Partnership

Welcome to The Skin Center. We are happy to provide you with the outstanding dermatologic care and service that you expect and deserve.

I understand that achieving my best possible health requires a "partnership" between me and my doctors and healthcare providers. My signature below signifies that I understand and agree with the following healthy choices.

Schedule Routine Exams and Recommended Health Screenings

I understand that my doctors recommend twice yearly **full body skin exam**s. I understand my responsibility to personally request and make a **separate appointment** for this exam apart from regular appointments. I know skin cancers may recur or new ones may grow since my last check. Without frequent and proper exams, I put myself at risk of undetected problems. I will try to make **follow up visits at least every 4-6 months,** especially if I have had a history of cancers. I always need to return sooner if I see any new or changing growths, or for spots that didn't resolve with freezing, biopsy, or other treatment.

Keep Appointments

I agree to cancel appointments at least 48 hours in advance to avoid a $50 fee, and reschedule missed ones. I understand that my doctors will want to know my progresses after my visit. Missed follow up may result in adverse health outcomes and become my personal responsibility. I agree that **patients under age 18 must be accompanied by a parent or legal guardian for medical services.** Unaccompanied minors can not be treated.

Schedule Procedure Appointments

I understand that prescriptions and **medical treatment can not be provided over the telephone.** I agree that thorough medical care requires a good faith exam. I understand that **special appointments are required for surgeries**, biopsies, and many procedures. Procedures may not be done at regular (non-surgical) appointments.

Always Get My Test Results

I understand that The Skin Center's policy is to see all patients to review results, normal or abnormal. I understand my responsibility to schedule a follow up visit for my results. I will not assume that my results are normal.

Properly Use Medications

I understand that **medications are prescribed solely for me** and my condition. I understand that Federal Law mandates never sharing prescription drugs with others. I agree to follow proper usage instructions and report any side effects. I know medications including antihistamines and narcotics may cause impaired judgment, drowsiness, alternations, and difficulty operating vehicles or machinery. I understand all medications carry potential side effects. I agree it is solely my responsibility to inform my provider if I have a reaction. For my safety, I need to be checked regularly (every 3-6 months) prior to medication refills. (Females only) I understand that medications should be stopped if I think I may be pregnant, or am pregnant/breastfeeding- unless previously cleared by my OB.

Mutual Privacy Agreement

To ensure patient privacy laws and transparent communication, I agree to communicate any questions or concerns at my visit, via telephone, 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.

Inform My Doctor If I Decide Not To Follow His/Her Recommended Treatment Plan

I understand that *not* following my treatment plan can have serious negative effects on my health. I will inform my doctor/ provider when I decide *not* to follow recommendations so that so I may be informed of risks. I will report problems after visits or treatments as soon as possible and return for any concerns of infection or wound healing.

If you need more information about your health or condition, please ask us.

~ Thank You for the Healthy Choice Partnership~

X_____

PRINT (PATIENT) NAME **DATE** **SIGNATURE** Patient (or parent if under age18) **Staff_____2**

**STAFF PLACE LABEL HERE

THANK YOU FOR CHOOSING THE SKIN CENTER FOR YOUR DERMATOLOGY SERVICES.

The Skin Center is committed to providing you with the best possible care. We are able to provide the outstanding level of medical services with the help of patients who fully understand their share of medical costs, and are agreeable to payment for their services. **The Skin Center has a "pay as you go" plan. All co-pays, deductibles, and co-insurances are collected at the time of the service instead of sending out monthly bills.** While we would like to be able to provide free services, unfortunately then we could not afford to keep our doors open. Providing medical services is very expensive including staffing, facilities rent, utilities, medical supplies, medications, sharps disposal, office supplies, taxes, and many other medical operating expenses. Please ask if you have any questions. Each visit is charged as a separate encounter. There are no guarantees or warranties on the human body. You may always 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. These procedures include, but are not limited to: freezing, "burning-off", skin tag removal, laser, acne surgery, slush, peels, biopsies, surgeries, injections, light therapy, Mohs, cyst drainage, mole or wart removal, etc.

INITIALS: Please initial each statement, affirming that you fully understand your responsibilities: ALL MUST BE SIGNED.

PPO INSURANCE & MEDICARE

X _____ The Skin Center has preferred provider contracts with insurances including **PPO Blue Cross, Blue Shield, Aetna, United, and Healthnet. One** insurance carrier is courtesy billed for me. I will check with my carrier before my visit to confirm coverage. I understand my responsibility to know my insurance plan and verify coverage for referrals to other doctors, recommended tests and laboratories. I agree that my doctor's office does not know my individual plan and is not authorized to make any guarantees regarding coverage. I may choose to self-bill any secondary insurance and list myself as the beneficiary only. (EPO's, NAP,& POS plans require a down payment before services.). The Skin Center can not accept patients with Kaiser or other plans that require a primary carrier to be billed and then denied; these cases will be self pay. **TSC accepts regular Medicare** and will bill for me (No HMO's). Federal Law mandates Medicare's annual $198 deductible. (changes annually).

SELF PAY/ NO INSURANCE:

X _____ The skin Center regularly sees self pay patients. Self pay means NO INSURANCE. A nonrefundable down payment of at least $295 is collected at check-in prior to being seen as a self pay patient. I must be truthful and present my insurance card if I have medical insurance or a high deductible plan. If I declare and go self pay, I understand that neither The Skin Center or I can later bill my insurance. I will pay for any additional labs, procedures, etc. I understand that the down payment is an approximate fee, and additional services will result in additional fees. Estimates are available.

NO: MED-ICAL / CAL-OPTIMA / FREEDOM / EPO/MONARCH / KAISER /HMO :

X_____ The Skin Center is **not a provider** of any state plans nor can we accept anyone with Medi-Cal. TSC can **not** see you as a patient if you have Medi-cal or Caloptima. Although TSC does **not have any HMO** contracts TSC does regularly see patients here outside of their HMO. TSC is not on Monarch Health, Kaiser, Scan. If I should decide to be seen outside of my plan, my visit will be considered self-pay and full payment for all services is due prior to my visit. I understand that a $295 down payment is collected at check-in prior to my visit. Any office procedures carry additional fees.

CO-PAYS, DEDUCTIBLES & CO-INSURANCE : Due in office, at the appointment

X _____ I understand that insurance plans legally and contractually obligate health care providers to collect my set co-pay at each and every visit. I understand that each time I come in, a co-pay will be due at check-in. I understand that if my yearly deductible has NOT been met, I will always pay a payment for the visit. I will receive credit for the deductible paid and a claim will be mailed to my insurance carrier indicating my applied payment. If I have overpaid, I will be issued a refund or credit to my account for any pending services. I understand that The Skin Center can not send statements for co-payments/ deductibles/prior account balances and therefore payment is expected at the time of service. Refunds are typically processed within 45 days and may take up to 90+ days based on insurance benefits.

LAB TESTS, PATHOLOGY CHARGES, & COSMETIC SERVICES:

X _____ If my visits include surgeries, biopsies, lab tests, or cultures, I understand that I will receive separate billings from companies performing services for me. All biopsies and surgeries result in a specimen being sent to pathology for examination, and therefore additional fees and outside charges. Cosmetic services are available as strictly self pay/ cash basis and are paid immediately at the time of the procedure. The Skin Center is not permitted to bill cosmetic services to patients or insurance. I understand The Skin Center is in no way responsible for my labs or elected medical care.

UNPAID ACCOUNTS, RETURNED CHECKS & MEDICAL RECORDS:

X _____ If payment in full is not received from my insurance carrier within 60 days, my full account balance will become my sole responsibility. I understand that insurance is a contract between me and my insurance and that The Skin Center is not a party to my contract and has no authority to become involved in insurance disputes other than to supply factual information. 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. I will personally need to contact my insurance if they do not cover my treatments. I agree to provide required information to my insurance on a timely fashion and report unpaid claims to the California insurance commissioner. I agree I am always ultimately responsible for medical services which I choose to receive, and timely account payment. 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, $45 collections fees, legal fees, and may cause an adverse incident on my credit report. Unpaid accounts may also be reported as earned income to the IRS with a 1099 form. Returned checks require a $25 fee. Unpaid bad checks are referred to The Orange County District Attorney for fraud report and legal remedy. My written notations like" payment in full" or other notes on checks deposited by TSC in any way constitute acceptance by TSC as payment in full or hinder TSC's ability to collect any remainder balance due by me on my account. I will cancel or reschedule an appointment at least 48 hours before the scheduled time. I will pay $50 for each missed appointment when I fail to cancel at least 48 hours in advance and $100 for each missed Mohs, cosmetic, or surgery appointments. I know that policies are created to ensure equal patient access. Copies of medical records are available within 15 days via U.S. mail upon written request and a prepaid $50 clerical fee and 25cents per page. Records are not available on walk-in or same day basis.

KINDLY DO NOT SIGN THIS FORM IF YOU DO NOT UNDERSTAND & AGREE TO ALL THE ABOVE CONDITIONS AND ASK TO DEFER YOUR APPOINTMENT.

Printed Patient Name _____ **Patient Signature) X** _____

(*or parent if patient< age 18)**

DATE Staff **3**

THE SKIN & WELLNESS CENTER PATIENT PRIVACY **2020R** rev 1/7/2020TSCFRM102

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 by writing our office.

You have the right to request that we restrict how protected health information about you is used or 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 company provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Company policy requires confirmation of the patient's government issued photo identification as well as the social security number for billing and collections.
- The Company has a Notice of Privacy Practices which the patient has the opportunity to review.
- The Company reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Company 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 Company may condition receipt of treatment upon the execution of this Consent.**

I agree that:

· The Company has permission to call or contact (email, call, text, fax etc.) patients, parents of any minors (less than age18), and/or their responsible financial guarantor for treatment, payment, or health care operations. The Company Policies include generally confirming patient appointments via phone or leaving messages on voice mail or answering machines. The company may call or contact patients for test, biopsy, other lab results, follow-ups, and visit reminders. The Company may relay medically relevant information to my other physician(s) and request information from my referring provider(s) related to my care. Medical photographs may be used for medical treatment, educational or demonstrational purposes as long as my identity is not revealed by accompanying text or information. The Company may mail out periodic letters, emails, or reminder postcards. I agree to the mutual privacy agreement and authorize the office to retain full copyrights to any communication or online posts related to my or my family's treatment and services. In case of medical emergency or need for urgent contact, listed patient emergency contacts may be contacted. To ensure safety of patients and staff, I understand and consent as a patient of the practice to the Company's 24 hour continuous security system and premises video monitoring system and policy in place.

I request that:

· The Company has permission to **discuss with the following additional designated individual** any aspect of my health, medical or surgical care, insurance, and financial payments, or other health care operations. I understand that without a specific written consent, parents may not be given over the telephone any information about their children who are age 18 and over. I understand that without my specific consent, the Company can not discuss my medical care with anyone not on this list, other than as per the above HIPAA designated policies.

NAME: PHONE: RELATIONSHIP:

PLEASE NOTE THAT THIS FORM IS THE SKIN & WELLNESS CENTER'S STANDARD HIPAA POLICY AND IS NOT MODIFIABLE. THE FORM MUST BE ACCEPTED IN ITS ENTIRETY FOR PROPER OPERATIONS. IF YOU DO NOT AGREE, PLEASE IMMEDIATELY ADVISE THE OFFICE AND DEFER YOUR APPOINTMENT.

_____ X _____

Print Name Patient **Signature (or parent if patient< age 18)**

Relationship to Patient (if other than patient) Mother/ father / legal guardian

Date staff_____ **4**

The Skin & Wellness Center

PLEASE PRINT and COMPLETE ALL SECTIONS **2020R**

REV1/7/2020

ALLERGIES to medications: ☐NONE ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ local Anesthesia
Other Allergies?
What reaction did you have?

MEDICATIONS:(Please DON'T forget to include **ANY and ALL** vitamins, aspirin, advil, herbal supplements, lotions, creams, ACNE treatments, hormones, etc.) ☐ see list attached ☐NONE

_____

_____

_____

MEDICAL HISTORY: (please **CHECK** all that apply to you)

☐ Acne ☐Rosacea ☐Accutane use	☐ Psoriasis ☐ Vitiligo	☐ Allergies/ Asthma
☐ Actinic Ketatosis (pre-cancers)	☐Thyroid disease/ ☐ Hashimoto	☐ High Blood Pressure
☐ Efudex use ☐Blue Light/ PDT	☐ Heart disease/ Attack	☐ Lupus/ Sjogren's
☐ Irregular moles	☐ Stomach Ulcer/ ☐H.pylori	☐ Cancer (not skin)
☐ Melanoma	☐ Diabetes	☐ Hepatitis A , B or C
☐ Skin cancer (Basal or Squamous)	☐ Fainting/ passing out	☐ HIV/AIDS

Any **Other**? _____
Any **Surgeries**? _____
Any moles removed? (where & when) _____

My Primary Care MD(s) is/were : Dr.

My last Dermatologist(s) was/were: Dr.

FAMILY history: Skin Cancer ☐ YES Relation:
Age:
Melanoma ☐ YES Relation: Age:

Women: **Pregnant** ☐ YES (**I WILL NOTIFY DOCTOR AT EACH VISIT)**
Nursing ☐ YES

Do you take **blood thinners**? ☐Aspirin ☐Coumadin ☐Plavix ☐Advil ☐vitamin E ☐garlic supplement

*Do you have a **pacemaker or Defibrillator**? **(PLEASE NOTIFY DOCTOR EACH VISIT)** ☐YES

*Do you have any **artificial joints**, implants or other artificial parts? ☐ YES

*Do you need to take **prophylactic antibiotics** before dental visits or surgeries? ☐ YES

I WILL ADVISE MY PROVIDERS AT EACH VISIT & TAKE ANY REQUIRED PRE-OPERATIVE ANTIBIOTICS.

I HAVE COMPLETED PLEASE MY MEDICAL HISTORY FORM THOROUGHLY AND HONESTLY. I UNDERSTAND THAT AN ACCURATE AND COMPLETE HISTORY IS VERY IMPORTANT FOR GOOD MEDICAL CARE. I certify that I have not omitted any parts of my medical history and have been truthful.

PATIENT SIGNATURE X _____ **DATE**_____
(Parent sign if patient <age 18)**

Reviewed by M.D. _____ **Date** _____ **Revd by M.D.** _____ **Date** _____

Reviewed by M.D. _____ **Date** _____ **Revd by M.D.** _____ **Date** _____

Reviewed by M.D. _____ **Date** _____ **Revd by M.D.** _____ **Date** _____

Reviewed by M.D. _____ **Date** _____ **Revd by M.D.** _____ **Date** _____

PRINT Patient NAME:

The Skin & Wellness Center

TSCFRM107 new rev 1/7/2020

NON-MEDICARE PATIENTS 2020R

I have initialed next to each statement and signed below, affirming that I fully understand these standard policies.

INITIALS **ALL SECTIONS NEED TO BE INITIALED & FORM SIGNED.**

X_____I understand and agree that I am financially responsible for payment for medical services and am expected to pay for all my services. I agree that insurance may cover some portion of medical fees, but not all. I understand that The Skin & Wellness Center ("TSC") is not in a position to provide free service, or reimburse me for elected medical treatments.

X_____I agree that high deductible plans save on monthly premiums but **require more out of pocket for each visit.** Based on my deductible, I will pre- pay an estimated down payment for my deductible and co-pay for any services which I choose to have.

X_____I understand that TSC does not mail out bills and offers a "pay as I go" plan. I will pre-pay my co-pays, deductibles, co-insurances, & account balances at the time of the service, at check-in order to avoid receiving monthly bills at home.

X_____ I understand and agree that all procedures have additional costs and are not included in a regular office visit fee. Procedures include, but are not limited to: freezing, "burning-off", skin tag removal, laser, light therapy, acne treatment, removal of white heads, slush, peels, biopsies, surgeries, injections, Mohs, cyst drainage, mole or wart removal, etc. I understand that lab or blood draw charges are not included in office fees and I will pay for any labs to the lab draw station (Quest or Labcorp) which I choose, or the pathology lab where my biopsies are sent.

X_____I understand that many medical problems may require multiple visits and repeat treatments, have complications, and may not get better despite treatments. I agree that there are **no guarantees or warranties for the human body** and will pay for each visit and procedure separately.

X_____ I agree that as a courtesy, one insurance plan is auto-billed for me. If payment in full is not received from my insurance carrier within 60 days, the balance will become my sole responsibility. After the initial billing, I will assume responsibility in contacting and collecting from the insurance company. I understand that insurance is not a guarantee of payment.

I will notify the front desk if there have been any changes to my insurance.
KINDLY DO NOT SIGN THIS FORM IF YOU DO NOT UNDERSTAND AND AGREE TO ALL THE ABOVE CONDITIONS.

Print Name_____ Patient Signature) _____

Date_____ **(**or parent if patient< age 18)** Staff_____ **5**