BH Skin DERMATOLOGY

Patient Information Form

Patient Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____City: _____Zip:_____

Social Security Number: _____ Driver's License Number: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

Primary Insurance: _____

Subscriber Number: _____ Group Number: _____

Secondary Insurance: _____

Subscriber Number: _____ Group Number: _____

Emergency Contact Name: _____Relationship to Patient: _____

Emergency Contact Address: _____

Emergency Contact Phone: _____ Emergency Contact Email: _____

Who is your Primary Care Physician: _____

How Were You Referred To Our Office:

☐ Primary Physician
☐ Other Physician: _____
☐ Friend: _____
☐ Relative: _____
☐ Google
☐ Yahoo / Bing
☐ Facebook / Twitter
☐ Yelp
☐ Other Internet: _____
☐ Other Source: _____

Authorization to Release Information and Assignment of Benefits

Please remember that insurance is considered a method of reimbursing for fees paid to the doctor and is not a substitute for payment. Some companies have fixed allowances for certain procedures, and others pay for a percentage of the charge. It is your responsibility to pay any deductible amounts, co-pays, co-insurance, or any other balance not paid for by your insurance.

I (the patient) consent to the use of stored credit card information to automatically pay for remaining patient balances as put forth in the financial policies. I directly assign all medical and surgical benefits to Don Mehrabi MD APMC and understand that I am financially responsible for all charges not covered by my insurance benefits. I authorize payment to be made to the provider. In the event that the payment is made to the policy holder, I agree to submit payment to this office immediately. If the account is not paid in full and prior arrangements have not been made, your account(s) may be referred to a collection agency. In the event that your account is referred to such an agency, you will be responsible for all attorney's fees and/or collection fees.

"I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement be as valid as the original. I have read and understand the information of this form. I certify the information is true and correct to the best of my knowledge."

Printed Name: _____

Signature: _____ Date: _____

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What Is Your PREFERRED PHARMACY and ADDRESS? _____

Please List The Medications You Are Taking and Doses:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List Your Medication Allergies and Reactions: _____

Preferred Language: ☐ English ☐ Spanish ☐ Farsi ☐ Armenian ☐ Arabic ☐ Other: _____

Ethnicity:

☐ White/Caucasian

☐ Hispanic/Latino

☐ Native American

☐ African American

☐ Indian

☐ Middle Eastern

☐ Other

Have you had a history of skin cancer, skin cancer surgery, or any other kind of skin surgery? ☐ Yes ☐ No

If yes, please list all of your skin cancers, locations, and dates: _____

_____

Do you have a FAMILY HISTORY of Melanoma? ☐ Yes ☐ No

If yes, who had the melanoma? _____

What medical problems do you have?

☐ Heart Disease ☐ High Cholesterol ☐ Hepatitis C ☐ HIV/AIDS ☐ Cancer Other: _____

What surgeries have you had? _____

Do you have a pacemaker? ☐ Yes ☐ No

Are you allergic to lidocaine? ☐ Yes ☐ No

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What is your **FIRST** problem today? _____

Where is it located? _____

How long have you had this problem? _____

Is your problem:
☐ Constant ☐ Episodic
☐ Mild ☐ Moderate ☐ Severe
☐ Stable ☐ Worsening ☐ Improving

What symptoms are you having? (check all that apply)

☐ None	☐ Oozing	☐ Crusting	☐ Itching
☐ Burning	☐ Growing	☐ Bleeding	☐ Painful
☐ Red	☐ Scarring	☐ Irritated	☐ Swollen

What makes this problem worse? (check all that apply)

☐ Nothing	☐ Menstrual Cycle	☐ Food	☐ Cold
☐ Pressure	☐ Stress	☐ Heat	☐ Sunlight

☐ Other: _____
What treatment(s) and medications have you had for this problem? _____
Comments: _____

What is your **SECOND** problem today? _____

Where is it located? _____

How long have you had this problem? _____

Is your problem:
☐ Constant ☐ Episodic
☐ Mild ☐ Moderate ☐ Severe
☐ Stable ☐ Worsening ☐ Improving

What symptoms are you having? (check all that apply)

☐ None	☐ Oozing	☐ Crusting	☐ Itching
☐ Burning	☐ Growing	☐ Bleeding	☐ Painful
☐ Red	☐ Scarring	☐ Irritated	☐ Swollen

What makes this problem worse? (check all that apply)

☐ Nothing	☐ Menstrual Cycle	☐ Food	☐ Cold
☐ Pressure	☐ Stress	☐ Heat	☐ Sunlight

☐ Other: _____
What treatment(s) and medications have you had for this problem? _____
Comments: _____

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Appointment/Cancellation/No Show Policy

Appointments

Patients who are late for any appointment may be asked to reschedule at the physician's discretion. Remember to bring all of your prescriptions, over-the-counter medicines, vitamins and supplements to each office visit. This will enable your doctor to review the medications at each visit.

Cancellations

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, **please give us at least 24 hours notice**. This courtesy makes it possible to give your reserved time to another patient who would like it. We know that your time is valuable. If you are unable to keep an appointment, **we ask that you cancel at least 24 hours in advance**. If this is not possible, call as soon as you can so that another patient can be given your appointment time.

Missed (Non-Cancelled) Appointments (Effective 10/1/2017)

We understand that occasional missed appointments can occur for a variety of reasons. **When you miss an appointment without canceling, someone else who could have been seen in your place is delayed unnecessarily. We track missed (non-cancelled) appointments. A "No Show/Late Cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time.** There will be a $**45** charge for a missed or non-cancelled appointment. An additional $**75** charge will be assessed for two consecutive missed appointments. All missed surgery and Mohs surgery appointments will result in a $**150** charge. Insurance will not cover charges for no show/late or late cancellation fees. These charges are in addition to any other charges you may have incurred. No refunds will be given. Repeated missed appointments may result in your physician sending a letter discharging you from the practice.

Payment

Payment is due in full at the time of service; no exceptions.

Signature: _____

Name: _____

Date: _____

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Financial Policies

Proof of Insurance: All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, or do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your coverage

Deductibles: Deductibles are due at time of service.

Claim Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. The balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Not Contracted: If you have a primary insurance that we are NOT contracted with, the total cost of the visit is your responsibility and due at the time of service. If you have a secondary insurance, we will submit ONE claim. If payment is made by either insurance company, you will get the reimbursement from our office in the form of a check. We do not accept secondary assignment of benefits.

Contracted: If you have a primary insurance that we are contracted with, you are responsible for any co-pay, coinsurance or deductible at the time of service. This arrangement is part of YOUR contract with YOUR insurance company. Failure on our part to collect co-pays and deductibles from patients is considered fraud. Please help us in upholding the law by paying your co-pays. If there is a balance remaining after the primary insurance has paid, we will submit ONE claim to your secondary insurance. You are responsible for payment of any office visits or procedures for which your company denies payment. We do not submit to the secondary insurance company for reimbursement of your co-pay. We do not accept secondary assignment of benefits. You are responsible for the patient's portion that is stated on the primary explanation of benefits.

Tertiary Insurance: We do NOT accept or bill third party insurance policies.

Responsible Party: We realize that many families are in a state of change. Divorced, separated, single parents and blended families are now common. In many of those families, the question of who is financially responsible for the child's care can be complicated. The policy in this office is that the parent/guardian, who is present with the minor requesting treatment, is responsible for payment at the time of service.

Statements: Any unanticipated co-pays or deductibles must be paid upon receipt of the first statement. Any balance outstanding for more than 90 days after the balance has been transferred to you will be sent to collections. Fees associated with the collection process will be added to your balance. Partial payments will

not be accepted unless otherwise negotiated. If a balance remains un-paid; you and your immediate family members may also be discharged from the practice.

Forms of Payment: For your convenience, we accept cash, MasterCard, Visa, American Express, Discover and Debit Cards ONLY. **No checks accepted in office**. In the event that a check is accepted and returned to us from the bank for any reason whatsoever, a **$45.00 return fee** will be added to your statement.

Credit Card Authorization: You hereby authorize Don Mehrabi MD APMC to obtain and store your credit card
information for payment of patient statement balances. Your credit card will be charged for the remainder of the patient balance after we have received your insurance payment. You have a right to request that we call you before we process this charge. A receipt will be included with your statement and the statement will be marked as PAID IN FULL

Late Fees and Interest Charges: Should an outstanding patient statement balance not be paid in full after 60 days, a $25.00 late fee may be assessed to your account PLUS a 6.5% finance charge on the balance. A second $25.00 late charge and 6.5% finance charge may be assessed to your account balance in at 90 days PAST DUE, and this amount will be sent to collections.

Cosmetic Services: Services that your insurance company determines are not medically necessary will require full payment at the time of service. Examples of such services are Botox treatment, microdermabrasion, chemical peels, sclerotherapy and removal of skin tags, normal moles, or benign keratosis.

Missed Appointments: Missing an appointment affects our providers as well as patients who have been waiting for appointments. Please call and cancel at least 24 hours before your appointment to help us accommodate other patients. Missed appointments can lead to a **$45.00 – $150.00** charge and discharge from the practice. Please refer to the Appointment/Cancellation/No Show Policy.

Medical Record Release: A $35.00 service fee may be assessed for copying medical records. A release of information form must be signed.

Referrals and Authorizations: It is your responsibility to obtain a referral, if one is required, from your primary care physician. Please check with your insurance company to find out if a referral is necessary. Coverage Change: If your insurance changes, please present your new card before your appointment so we can make the appropriate changes to help you receive your maximum benefits. **It is YOUR responsibility to understand your insurance policy and have the correct authorization prior to the visit and/or procedure. All charges for visits or procedures done without a valid authorization will be the SOLE RESPONSIBILITY of the patient.**

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Identity Theft: Our system is secured. In the event that there is a breach of our electronic medical records or financial records, you will be notified and a full investigation will be performed. We value your personal information and will take use the highest and full extent of the law to persecute anyone who is involved in accessing, disseminating, or using stored personal information. Identity theft or personal information breeches will be recognized by either the patient's reporting financial institution or insurance inquiry, or by our routine auditing of our system security. Any breach will be recognized and login information will be analyzed. We will contact the appropriate authorities and report any infraction. In addition, if the breach is electronic, we will shut down our system for a period of time to reinsure its safety and perform diagnostic testing. All persons involved will be prosecuted. Our practice will not be financially liable for breaches of personal information.

Thank you for thoroughly reading and understanding our Financial Policy. Your signature below indicates that you have read, understand and agree to this financial policy.

Signature: _____

Name: _____

Date: _____

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Medical Photography

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact any agent of this office.

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to medical researchers and scientists that regularly use these publications in their professional education. Although these photographs will be used without any identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

For patients 7 to 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to the use of my images as outlined above.

Signature: _____

Name: _____

Date: _____

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Patient Information Form

Authorization for Treatment and Medical Records Release

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Don Mehrabi MD will share patient health information according to federal and state law for treatment, payment, and operations.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies have fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-pays, co-insurance, or any other balance not paid for you by your insurance. I further consent to the use of stored credit card information to automatically pay for remaining patient balances as put forth in the financial policies.

I directly assign all medical and surgical benefits to Don Mehrabi MD APMC and understand that I am financially responsible for all charges not covered by my insurance benefits. I authorize payment to be made to the provider. In the event that the payment is made to the policy holder, I agree to submit payment in full to this office immediately.

If the account is not paid in full and prior arrangements have not been made, your account(s) may be referred to a collection agency. In the event that your account is referred to such an agency, you will be responsible for all attorney and/or collection fees.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I have read and understand the information on this form.

I certify the information is true and correct to the best of my knowledge.

Signature: _____

Name: _____

Date: _____

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HIPAA Information and Consent

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI).

These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which ma y include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

10. Identity Theft: Our system is secured. In the event that there is a breach of our electronic medical records or financial records, you will be notified and a full investigation will be performed. We value your personal information and will take and use the highest and full extent of the law to prosecute anyone who is involved in accessing, disseminating, or using stored personal information. Identity theft or personal information breeches will be recognized by either the patient's reporting, financial institution or insurance inquiry, or by our routine auditing of our system security. Any breach will be recognized and login information will be analyzed. We will contact the appropriate authorities and report any infraction. In addition, if the breach is electronic, we will shut down our system for a period of time to reinsure its safety and perform diagnostic testing. All persons involved will be prosecuted. Our practice will not be financially liable for breaches of personal information.

Signature: _____

Name: _____

Date: _____