SOCALDERM
Southern California Dermatology & Southern California Clinical Research
SINCE 1982

BARTLOW, GOODMAN, BARON, MUIRHEAD, SOUNG
SAEDLER PA-C, PARSA PA-C, FRAZIER PA-C, YOUNG PA-C
FREESEMANN PA, BOND - ESTHETICIAN

PATIENT INTRODUCTION

CHART # _____

PLEASE PRINT

DATE: _____

HOME PHONE: (_____)_____ BIRTHDATE: _____

CELL PHONE: (_____)_____ **EMAIL:** _____

ATIENT _____ AGE: _____ Male____ Female____
FIRST MIDDLE MAIDEN LAST

IAILING ADDRESS _____
STREET APT.# CITY STATE ZIP

SOCIAL SECURITY #_____ OCCUPATION: _____

NAME OF PERSON LEGALLY RESPONSIBLE
(If patient is a minor, name of parent, guardian, etc.)_____

SOCIAL SECURITY #_____ DATE OF BIRTH _____

EMPLOYED BY_____ WORK PHONE (_____) _____

BUSINESS ADDRESS _____
STREET CITY STATE ZIP

NAME OF SPOUSE _____ DATE OF BIRTH: _____
FIRST MIDDLE LAST

SOCIAL SECURITY #_____ OCCUPATION _____

SPOUSE EMPLOYED BY_____ WORK PHONE (_____)_____

BUSINESS ADDRESS _____
STREET CITY STATE ZIP

CONTACT (In case of emergency) _____ ( )_____
FULL NAME ADDRESS PHONE

PRIMARY INSURANCE

Insurance Company _____ ID#_____
Group #/Employer #_____
Phone #_____ Name of subscriber?_____
Is this an Individual Policy_____ or Employer Policy_____

SECONDARY INSURANCE

Insurance Company _____ ID#_____
Group #/Employer #_____
Phone #_____ Name of subscriber?_____
Is this an Individual Policy_____ or Employer Policy_____

REFERRED BY X_____ (_____)_____
FULL NAME ADDRESS PHONE

AUTHORIZATION FOR MEDICAL TREATMENT, RELEASE OF MEDICAL INFORMATION TO INSURANCE COMPANY AND ASSIGNMENT OF BENEFITS

I/We do hereby consent to and authorize the performance of all treatments, surgery and medical services by the physicians and staff, which they may deem advisable. I also hereby assign, authorize, and/or allow payment of benefits directly to SOCALDERM for the medical benefits otherwise payable to me for services described. I authorize SOCALDERM to release any information acquired in the course of my examination or treatment to my insurance company or provider rendering care. I also authorize any provider to release to SOCALDERM any information including diagnosis and records of treatment or examination rendered to me during the period from_____ to _____

X _____ *TURN THIS PAGE OVER*

PATIENT FINANCIAL POLICY FOR SOCALDERM (3/03/2008)

It is the policy of this office to provide as much assistance as necessary concerning financial arrangements. We will try to ensure that you are aware of all possible financial matters on your first visit. As a service provided to you, we will bill your Health Plan, provide follow-up in 30 and 60 days (at which time you will be financially responsible) and a statement to you if there is any patient balance.

The undersigned hereby acknowledges that he/she has been informed that medical services provided may not be approved for payment/may not be covered services under their insurance plan. Therefore the undersigned agrees that he/she will bear full financial responsibility for payment of all charges for these services.

If applicable: Cash Patients. I hereby understand that I am a cash patient. I further understand that I will continue to be a cash patient even if I prove I have insurance at a later date for previous dates of treatment. If I am an HMO patient, I waive all rights for SOCALDERM to bill my HMO nor am I eligible for a refund.

Initial_____

If applicable: Patient Financial Responsibility. I hereby attest that I am an eligible member of a contracted health plan as noted. I agree that should it be determined that I am ineligible or services are denied me under the Health Plan noted below, that I will be responsible for payment to SOCALDERM or their agents for those services deemed disallowed, ineligible or not covered.

Initial_____

If applicable: Out of Network Waiver Form. Your signature below signifies that you clearly understand that SOCALDERM may not be a member of your medical group that you have signed up with. Because the doctor may not be on your plan, the expenses incurred for medical visits will be your responsibility. This means that you will have to pay the doctors' charges in full at the end of your visits.

Initial_____

If applicable: POS without authorization. You understand that in order to use the HMO option of your Health Plan that a prior authorization from your Medical Group is required. Without prior authorization, your Medical Group is not responsible to pay for any services performed today. You choose to use your PPO, POS, or Self Referral option and agree that you are financially responsible for any co-insurance, deductible and co-payment in accordance with your policy. You accept full financial responsibility for services provided and that your Medical Group will not reimburse you for these expenses.

Initial_____

If applicable: Access Plus (Blue Cross/Blue Shield). This plan allows you to come for an evaluation to specialists within your selected IPA/Medical Group. The physician is allowed to do a consultation and, in certain IPAs, treat. If the recommended treatment is not within our responsibility, then you have to go back to your PCP for further evaluation and/or treatment.

Initial_____

Please feel free to contact our billing department for any assistance or information that you may need. They will be happy to answer any questions that you may have concerning your account. Sometimes, problems can be worked out with just a phone call or letter. We do offer Visa/Mastercard as a payment option. It is also our policy to report bad accounts to a credit agency.

.....

I hereby assume all financial responsibility for the account of _____. I will ensure that I provide accurate, correct information for proper billing at all times and notify SOCALDERM of any changes at any time a change occurs.

Date: _____ **Responsible person's signature:** X_____

(Authorized adult/guardian/emancipated minor)

Date: _____ Witness: _____

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NAME:_____ DATE OF BIRTH:_____

CHART #_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

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Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____

What brings you to our office today: (reason for visit)

_____
_____

Name: _____ **Date of Birth**: _____

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Social History: (Please circle one)

Cigarette Smoking:	Alcohol Use:	Language:
Never smoked	YES	English
Quit: former smoker	NO	Spanish
Smokes less than daily		Other:_____
Smokes daily		

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

Occupation and Workplace_____

Place of Residence_____

Pharmacy Information:

Name:_____ Phone number: _____

Street:_____ City/Zipcode:_____

Primary Care Physician:

Name : _____ Phone number: _____

Address: _____

_____ _____

Patient/Parent or Guardian Signature **Date**

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Dear Patient:

It is our pleasure to serve as your Dermatology Group. Our goal is to provide you the highest quality dermatologic care.

AUTHORIZED SERVICES

If your insurance requires an authorization from your primary care physician, we are happy to consult and treat you for the specific covered condition you were referred for. If you have other conditions or skin concerns which are not covered, we will be happy to evaluate those as well. However, you will be financially responsible for the evaluation and treatment of non-covered conditions.

NON-COVERED SKIN CONDITIONS

Some skin conditions are not covered benefits, even if mentioned in your authorization. These include Benign and Cosmetic skin conditions. Some examples include:

BENIGN: skin tags, benign moles(nevi), non-inflamed skin cysts.

COSMETIC: Lentigos ("age spots"), broken capillaries, wrinkles.

ELECTIVE PROCEDURES

We are a full service Dermatology Group and offer the most current treatment of benign and cosmetic skin conditions as well as all skin diseases. If you are interested in treatment of any benign or cosmetic procedures, please inquire during your visit. Examples include:

REMOVAL OF BENIGN MOLES OR OTHER GROWTHS
SCLEROTHERAPY FOR UNSIGHTLY LEG VEINS
COLLAGEN & BOTOX INJECTIONS FOR WRINKLES
CHEMICAL PEELS FOR SKIN REJUVENATION
FACIALS FOR SKIN REJUVENATION AND ACNE TREATMENT
IPL PHOTOFACIAL TREATMENTS FOR ROSACEA, FACIAL SPIDER VEINS AND SUN DAMAGE SKIN.

Thank you.

Sincerely,

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Instructions for you when seeing Drs. Bartlow, Goodman, Baron, Muirhead, Soung, Physician Assistants, Pauline Saedler, Goli Parsa, Sarah Frazier, Amber Young and Suzanne Freesemann, A Dermatology Surgical & Medical Group, 1125 E 17th Street Suite W-248, W-244 (West Building) Santa Ana CA 92701 Phone: (714) 547-5151.

Please bring the *completed* attached forms with you when you come in for your appointment. This will save time for you and us. Please remember to bring the following:

1. A list of any prescription and non-prescription medications you are taking.
2. **You must bring ALL insurance cards, without them you will be required to pay cash.**
3. Please call if you are going to be late.
4. If you need to cancel or reschedule, please call the **working day** before so others can use your appointment time. We charge a $25 appointment no-show fee and $100 for surgery no-show.
5. Your co-payment, if you have one, is requested at the time of the visit. We charge a $25 billing fee if you choose to have us bill you for it or you will have to make another appointment.
6. If the patient is a minor, please ensure that a parent/guardian accompanies them.
7. If someone has guardianship over the patient, please bring appropriate documents.

A map is located in this packet for your convenience. You may also visit our website at www.socalderm.org for driving directions. As you come into the complex, we are located in the left rear building, the "West" building, on the 2nd floor, look for the dermatology sign above our office.

PLEASE SHOW UP 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

THANK YOU

Authorization For Use or Disclosure of Protected Health Information

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1125 E 17th Street, W-248, 244, Santa Ana, CA 92701 • (714) 547-5151

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning

X _____

(*patient name and address*) as follows:

Any and all health information other than psychotherapy notes may be released, including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, exc specifically provided below:

_____

This health information may be disclosed to:

X _____

(*Name and address of person to use or receive the health information*) NAME OF FAMILY MEMBER

The information may be used only for the following purposes (if you do not want to explain the purpose, write " request of the individual

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than ano health care provider, health plan or health care clearinghouse, under California law all recipients of health care informat prohibited from re-disclosing it except as specifically required or permitted by law.

Effect of Refusal to Sign Authorization

I understand that my health care treatment or benefits will not be affected whether I sign or do not sign this form.

This authorization is effective now and will remain in effect until _____
(*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.

Signed: X _____ Dated: _____

Print Name: _____

f not signed by the patient, please indicate:

Relationship:

- ☐ parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient **
- ☐ spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

lame of patient: _____

TURN OVER THIS PAGE

Signed: _____ Dated: _____

Treating Physician

**For the release of records (1) protected by the Lanterman-Petris-Short Act (LPS) or (2) containing HIV test results, a separate authorization is required for each separate disclosure. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may b released. Under HIPAA, an authorization for release of psychotherapy notes may not be combined with an authorization involving any other type of health informatio (except other psychotherapy notes).*

*** It is unclear whether the beneficiary or personal representative of a deceased patient can obtain and disclose certain records containing HIV test results.*

Acknowledgment of Receipt of Notice of Privacy Practices

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1125 E 17th Street, W-248
Santa Ana, CA 92701

Diana Galloway, Administrator, (714) 547-5151

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by mail at:

_____.

Signed: X_____ Date: _____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate:

Relationship:

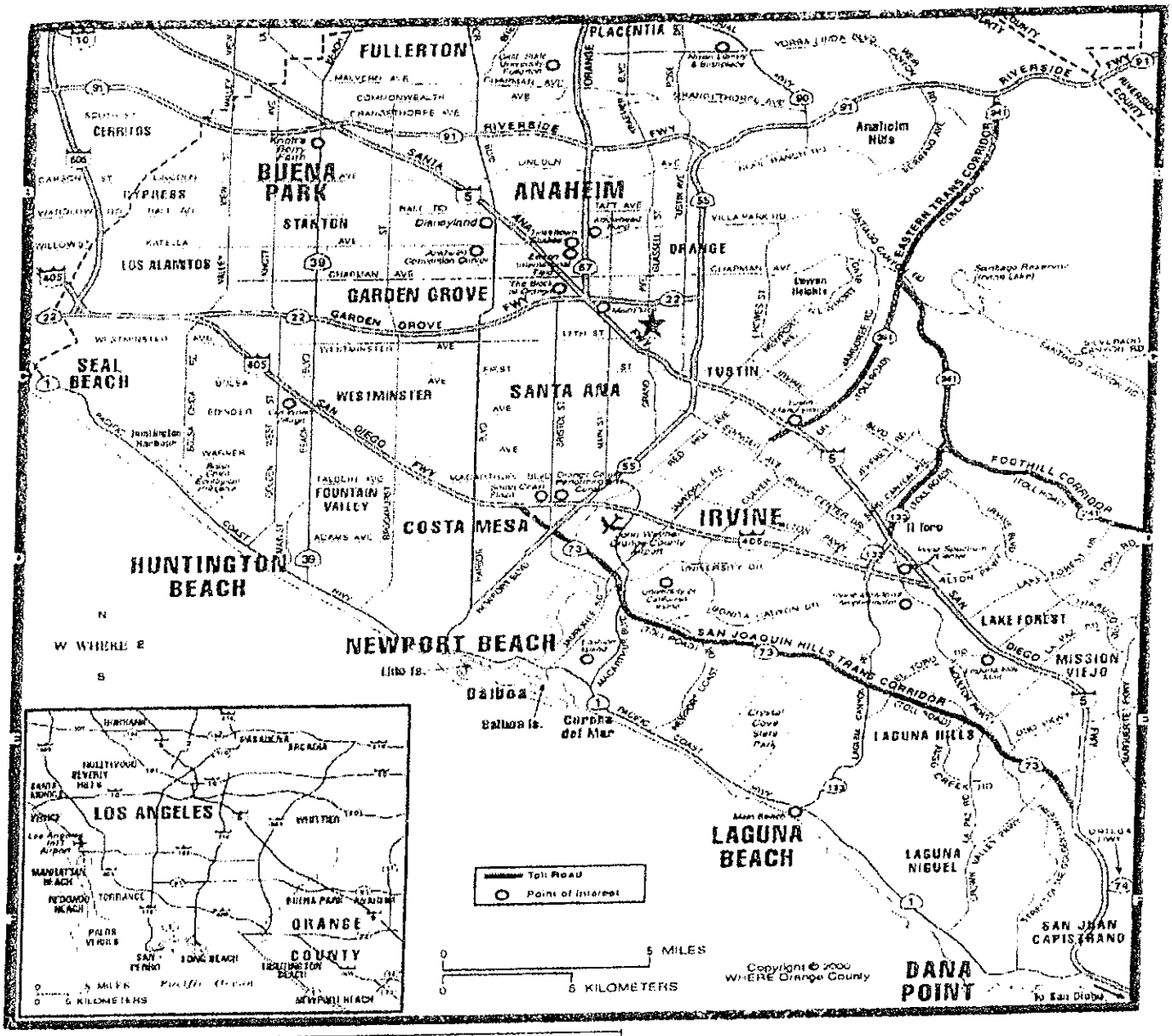
☐ parent or guardian of minor patient

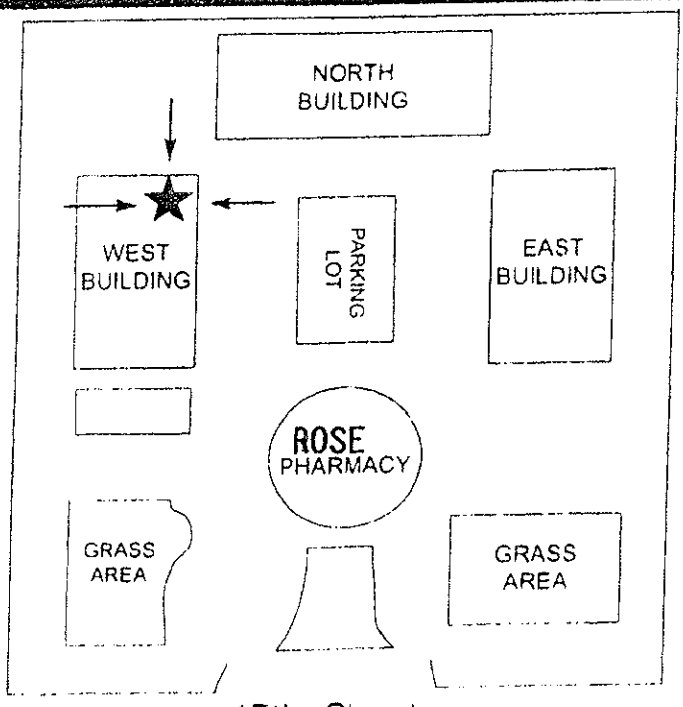
☐ guardian or conservator of an incompetent patient

☐ beneficiary or personal representative of deceased patient

Name of Patient:_____

SEE BACK SIDE





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1125 E. 17th Street
Suite #248 - West Building
Santa Ana, (714) 547-5151

***We are in the North Park Plaza, on the North side of the Street. (West of Grand Ave.) Next to the railroad tracks & Macdonald's.

1013-2