REGISTRATION FORM

PATIENT INFORMATION **(Please Print)** **Today's Date** _____

Name (Last,First,MI)_____ **Date of Birth** _____

Address _____ _____

City State Zip Email

Phone Numbers (including area code) _____ _____ _____

Home Cell Work

SS# _____ **Age** _____ **Sex:** M F **Martial Status** _____ **Occupation** _____

Required

Emergency Contact: Name _____ **Relationship** _____ **Phone** _____

INSURED OR PERSON FINANCIALLY RESPONSIBLE (if different from patient)

Name (last,first,MI) _____ Date of Birth _____ Sex _____

Address _____

City State Zip

SS# _____ **Phone Numbers**(including area code) _____ _____

Required Home Work

INSURANCE INFORMATION (**MUST present insurance card at time of check-in**)

Medicare ( ) Yes ( ) No Number: _____

HMO ( ) Yes ( ) No Primary Care Doctor: _____ Phone: _____

Primary Insurance **Secondary Insurance**

Ins. Company Name _____ Ins. Company Name _____

Statement of Patient Rights: The patient has the right to choose his/her own physician. The patient has the right to choose his/her own medical facility or hospital. The patient has the right to privacy, confidentiality of medical records, and confidentiality of any conversations he/she may have with any employees. The patient has the right to be free of abuse and harmful situations. It is the right of the patient to agree or disagree with the type of treatment and/or medication being suggested. It is the responsibility of the patient to ask questions about the recommendations, and if agreeing to treatment, to follow treatment. If refusing treatment, it eliminates the physician and staff from any patient outcomes.

Signature on File: Insurance claim forms are processed electronically. To facilitate this process, your signature is maintained 'on file' for this purpose.

Authorization and Assignment: I authorize Palos Verdes Dermatology Associates, Inc. to act as my agent to furnish information to my insurance carriers concerning my treatment and I assign to the practice all payments for medical services rendered. I also authorize Palos Verdes Dermatology Associates, Inc. to use and disclose my protected health information for medical diagnosis, treatment, and billing.

Responsibility for Payments: By signing below, I understand that I am responsible for payment for all services provided to me by Palos Verdes Dermatology Associates, Inc. ("PVDA"). If I am not the patient, I understand that by signing below, I am personally responsible for all the fees incurred by _____ (name of patient). I understand that I am responsible for payment whether there is any applicable insurance coverage or not. If PVDA bills insurance, they do so as a courtesy only and that I am actually responsible to obtain insurance payment. I am responsible for any fees not covered by insurance. Fees are due on the date service is provided. Interest will accrue at 1.5% monthly (18% annually) on any unpaid fees commencing on the date of service. In addition, a one-time delinquency fee equal to 10% of the unpaid balance shall be due on any unpaid balance. Any unpaid balance may be assigned for collection to a collection agency at any time at PVDA's sole discretion. If legal proceedings are started to collect any unpaid balance, I will additionally be responsible for any attorney fees and court costs incurred by PVDA. I have read and understood the above and I have no questions regarding payment terms.

HMO Patients: Patients are responsible for obtaining proper authorization or referral forms PRIOR to their visit. Your HMO insurance will not cover your visit without the proper authorization. In that case, the doctor would be happy to see you on a cash basis, but you will not be reimbursed for the charges. It is the patient's responsibility to confirm that the doctor is contracted with their HMO insurance plan.

Unauthorized and Non-covered Services: I understand that I am responsible for any amount not covered by my insurance company. I also understand that it is my responsibility to be aware of any need for an advance referral, co-pay, and pre-authorizations.

Returned Checks: There will be a $25.00 charge for returned checks. The patient will then be required to pay with cash or money order within 10 days to avoid collections actions.

Palos Verdes Dermatology Associates, Inc. reserves the right to limit or deny services to any person who is fraudulent with personal, medical or insurance

Printed Name: _____ **Signature:**_____ **Date:**_____

SIGNATURE OF PATIENT OR FINANCIALLY RESPONSIBLE PARTY

Palos Verdes Dermatology Associates, Inc. | 550 Deep Valley Drive, Suite 283, Rolling Hills Estates, CA 90274 |Phone: (310)541-7800 Fax: (310)541-7808

Name I prefer to be called: _____

PLEASE DETAIL THE REASON FOR TODAY'S VISIT

	Problem	Location	Severity	Duration	Previous Treatments	What makes it better or worse?
Problem#1						
Problem #2						

Do you have any other rashes ? Yes or No
Are you under significant stress? Yes or No
Do you have problems with healing? Yes or No
Do you have any problems with allergy or your immune system ? yes or no
Do you have problems with scarring? Yes or No
Do you have problems with bleeding? Yes or No

PAST MEDICAL HISTORY (Please **circle** all that apply)

Anxiety
Depression
Arthritis
Artificial Joints
Diabetes
End Stage Renal Disease
Hearing Loss
Heart Attack/Stroke
Hepatitis B or C
HIV/AIDS
Leukemia or Lymphoma
Radiation
Cancer:_____
Other:_____
None

PAST SKIN DISEASE HISTORY (Please **circle** all that apply)

Actinic Keratoses
Basal Cell Carcinoma
Melanoma
Squamous Cell Carcinoma
Other:_____
None

PAST SURGICAL HISTORY (Please **circle** all that apply)

Heart Valve Replacement
Joint Replacement
Other:_____
None

☐ Do you have an immediate family history of melanoma? Yes or No. If yes, whom ? _____
☐ Are there any pertinent or major skin problems that run in your family ? _____

MEDICATIONS(Please list all your medications, including, vitamins and supplements, doses & frequencies, tablet or liquid)

Allergies to Medications (Please list any medication allergies, and the type of reaction that occurred)

_____

Preferred Pharmacy: _____ **Location:** _____
Primary Care Doctor:_____ **Referring Doctor:** _____

Dermatology Alerts (Please **circle any** of these important alerts if they apply to you)

Allergy to lidocaine
Rapid heartbeat with epinephrine
Allergy to adhesive
Allergy to topical antibiotics
Artificial heart valve
Artificial joints within last 2 years
Premedication prior to procedures
Blood thinners
Defibrillator
Pacemaker
Pregnant, planning or nursing
Other:_____

RELEASE OF MEDICAL RECORDS

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

Social Security # : _____

By signing, I give authorization to release my protected health information to the following medical offices and/or those directly associated with my care

The information you may release subject to this signed release form is as follows:

☐ Complete Medical Records ☐ Progress Notes ☐ Lab Reports

☐ X-ray / Ultrasound Reports ☐ Pathology Reports ☐ Other (Specify below)

Please list providers information for which your protected health information can be released to

PCP: _____ _____ _____
Provider Name Phone Fax

Other: _____ _____ _____
Provider Name Phone Fax

Other: _____ _____ _____
Provider Name Phone Fax

Other: _____ _____ _____
Provider Name Phone Fax

_____
Signature of Patient/Parent/Legal Guardian **Date**

_____
Patient Name (Printed)

PATIENT HIPAA COMMUNICATION FORM

Patient Name: _____

A. FAMILY AND FRIENDS: It Is the office policy of MIND not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian,(ii)other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment),(iv) in emergency situations, or (v) as otherwise permitted by the health insurance portability and Accountability Act of 1996(HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updates to this form must be made in person.

_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone
_____	_____	_____
Name	Relationship	Phone

B. ALTERNATIVE COMMUNICATION: I wish to be contacted in the following manner.
(Check all that apply)

Home Phone_____

_____ Okay to leave message with details

_____ Leave a call back number only

Cell Phone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Work Telephone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Written Communication

_____ Okay to mail to home address

X_____ _____ _____

Patient or representative signature **Relationship to patient** **Date**

Patient Release for Photography/Visual Recording

The undersigned, _____, a patient of Palos Verdes Dermatology Associates, Inc. consents to be photographed and/or visually recorded with the understanding that these visual recordings, still images, and adaptations may be used anonymously for professional and patient educational purposes.

The undersigned grants Palos Verdes Dermatology Associates, Inc. the ongoing unrestricted right to the use of these images and acknowledges that he/she relinquishes all rights, title, and interest in these materials, or any right to profit or gain directly or indirectly realized through the use of these materials.

This form and the effect of my consent have been fully explained to me and any questions have been fully answered to my satisfaction.

Date: _____ **Signature:** _____

Witnessed: _____

Cancellation Policy

We must receive cancellation notice within 24 hours of a scheduled appointment time; otherwise you may be subject to the following cancellation fees:

- $50.00 for a missed office visit
- $250.00 for a missed surgery appointment
- $300.00 for a missed Mohs surgery appointment

Patient 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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on 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 related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron 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 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 if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate 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, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti 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 Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations 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 once 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, or 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 Effective as of the date of first medical services.

_____ _____
Patient's or Patient Representative's Initials Date

If any provision if this arbitration agreement is held invalid of 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:_____ _____
Patient's or Patient Representative's Signature (Date)

By: _____ _____
Physician's or Authorized Representative's (Date)

By: _____
Print Patient's Name

By:_____ _____
Print or Stamp Name of Physician, (If Representative, Print Name and Relationship to Patient)
Palos Verdes Dermatology Associates

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

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide If you want to give permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can: File a complaint with your provider or health insurer or file a complaint with the U.S Government.

You also have the right to ask your provider or health insurer questions about your rights. You can also learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who must follow this law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing, homes, and many other health care providers.
- Health insurance companies, HMO, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What information is protected?

- Information your doctors, nurses, and other healthcare providers put in your medical history.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic or healthcare provider.
- Most other health information about you, held by those who must follow this law.

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used or shared, taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your healthcare, with your family, relatives, friends or others you identify who are involved with your healthcare or healthcare bills unless you object to protect the public's health, such as reporting when the flu is in your area, or to make required reports to police, such as reporting un shot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer
- Use or share your information for marketing or advertising purposes.
- Share private notes about your mental health counseling sessions.

Patient Acknowledgement: I acknowledge receipt of this information regarding my rights to PHI privacy.

Signature_____ **Date**_____