CONEJO DERMATOLOGY MEDICAL GROUP

Dear Patient,

On behalf of our entire staff, we would like to welcome and thank you for choosing Conejo Dermatology Medical Group for your dermatology care. We would like to also take this opportunity to assist you with our registration process and address common concerns and questions.

Enclosed, please find the following packet:
A PATIENT REGISTRATION FORM
A MEDICAL HISTORY FORM
A PROTECTED HEALTH INFORMATION (PHI) FORM
AN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
A BILLING PRACTICES FORM

Please also feel free to read or download a copy of our Notice of Privacy Practices also located on our web site.

You can download these forms to fill out or fill out and then print the forms.

All forms will need to be brought in along with a Driver's License or another picture ID as well as a current insurance card if you wish to have your insurance(s) billed.

We look forward to meeting you.

PATIENT REGISTRATION FORM
PATIENT INFORMATION:

NAME: (LAST, FIRST, MI)_____

ADDRESS: _____ZIP CODE_____

CITY_____ STATE:_____

HOME PHONE: _____CELL PHONE:_____ BUSINESS PHONE: _____

EMERGENCY CONTACT AND PHONE: _____

DATE OF BIRTH: _____ GENDER: MALE ☐ FEMALE ☐ MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W

DRIVERS LICENSE: _____ OCCUPATION: _____ WORK #:_____

PREFERRED APPPOINTMENT CONFIRMATION METHOD: **PROVIDE ONLY ONE**

EMAIL-- _____TEXT -- CELL #_____ AND CARRIER_____

RESPONSIBLE PARTY IF OTHER THAN PATIENT OR IF PATIENT IS UNDER 18 YRS OF AGE

NAME: (LAST, FIRST, MI)_____

ADDRESS: _____ZIP CODE:_____CITY_____STATE_____

HOME PHONE #_____CELL:_____DRIVERS LICENSE: _____

PRIMARY INSURANCE: PPO ☐ MEDICARE ☐ OTHER ☐ INSURANCE CO:_____

SUBSCRIBER NAME:_____ COPAY:_____DEDUCTIBLE:_____

SUBSCRIBER ID#: _____SUBSCRIBER DOB:_____

RELATIONSHIP TO INSURED: ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

SECONDARY INSURANCE: PPO ☐ MEDICARE ☐ OTHER ☐ INSURANCE CO:_____

SUBSCRIBER NAME: _____CO-PAY:_____ DEDUCTIBLE:_____

SUBSCRIBER ID #: _____SUBSCRIBER DOB: _____

RELATIONSHIP TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

***PERMISSION FOR CONEJO DERMATOLOGY TO TAKE CLINICAL PHOTOS: YES: ☐ NO ☐**

ON MY BEHALF I AUTHORIZE: _____TO RECEIVE MEDICAL INFORMATION ON MY BEHALF UPON REQUEST.

REFERRED BY:_____

_____ _____
SIGNATURE OF RESPONSIBLE PARTY DATE

MEDICAL HISTORY FORM

Patient_____ DOB:_____Date_____

Allergies:_____ **Current Medications**:_____

_____ _____

Reason for Today's visit (Chief Complaint) _____

_____

Current or past problems (Review of Systems):

	Yes	No	(If yes, explain)
Skin	☐	☐	_____
Heart / Lung	☐	☐	_____
Hypertension	☐	☐	_____
Blood/Coagulation Disorders	☐	☐	_____
Immune Disorders	☐	☐	_____
Allergic Disorders	☐	☐	_____
Gastrointestinal Disorders	☐	☐	_____
Liver Disease	☐	☐	_____
Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid Disease	☐	☐	_____
Arthritis/Joint Disease	☐	☐	_____
Headaches/Seizures	☐	☐	_____
Psychological Disorder	☐	☐	_____
Infectious Diseases	☐	☐	_____
Past Surgeries	☐	☐	_____
History of any Cancer	☐	☐	_____

Other Medical Issues

Females: Are you pregnant? yes ☐ no ☐ Are you planning to become pregnant soon yes ☐ no ☐

Family History: (Past family & Social History)

Mother: Living / Deceased ___ Age Father: Living / Deceased ___ Age

Number of children ____ Ages: _____

Check the following medical conditions that have occurred in your family:

	Mother	Father	Blood Relative
Diabetes	☐	☐	_____
Eczema	☐	☐	_____
Melanoma	☐	☐	_____
Psoriasis	☐	☐	_____
Skin Cancer	☐	☐	_____
Immune disorders	☐	☐	_____
Breast Cancer	☐	☐	_____

Social History:

Do you live alone? ☐ yes ☐ no **Do you smoke? ☐ yes ☐ no**

Do you drink alcohol? ☐ yes ☐ no Occasional ☐ Moderate ☐ Heavy ☐

Occupation:_____ Hobbies/Leisure: _____

Name of your primary care Physician: _____ City Location:_____

Physician Reviewed _____ Date_____

PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE RECORD

Authorized Methods of Communication (check all that apply)

□ Residence Telephone	□ Work Telephone	□ Written Correspondence	□ Other (Specify)
Number: ( )	Number: ( )	□ Mail/Delivery Service	
□ Leave call back number only: do not leave message	□ Leave call back number only: do not leave message	□ Fax: Specify home or work ( )	
□ Okay to leave detailed message with person	□ Okay to leave detailed message with person	□ E Mail @ Residence:	
□ Okay to leave detailed message on answering machine	□ Okay to leave detailed message on personal voicemail	□ E-Mail @ Work:	

Patient Signature: _____Date: _____

ACKNOWLEDGMENT
OF
NOTICE OF PRIVACY PRACTICES

For the convenience of our patients, our NOTICE OF PRIVACY PRACTICES is available at the information center for review. Please feel free to take a copy with you at any time. A copy is also available at our web site for your review.

I hereby acknowledge that I have been offered a copy of this medical office's NOTICE OF PRIVACY PRACTICES. I further acknowledge that a copy of the current notice is posted in the reception area of this medical office. If amended, I will be provided with a copy of the amended NOTICE OF PRIVACY PRACTICES upon request and that copies of the amended notice will be posted in the reception area updating the original.

I understand that I can refuse to sign this acknowledgement if I so choose.

Signed:_____ Print Name:_____

Date_____Telephone:_____

If not signed by the patient, please indicate below:

_____ parent/*guardian of minor
_____*guardian or *conservatory of an adult patient
_____*beneficiary or *personal representative of a deceased patient

*please offer proof of guardianship

Name of Patient:_____

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office use only

_____ witness

_____ witness

Billing Practices/ Frequently Asked Questions:
Because medical and surgical benefits vary from insurance to insurance, we have addressed some common concerns and issues.

MEDICAL / SURGICAL SERVICES PROVIDED:
Dermatology services vary in nature. The initial office visit or any subsequent visit may be considered either medical or surgical in nature, according to your insurance carrier.
-A visit that is considered medical would be limited to consulting and developing a medical treatment plan including medical advice and prescribing medications.
-A visit that is considered surgical might include liquid nitrogen therapy (cryosurgery) or the biopsy or excision of a particular lesion. These are all procedures that fall under the category of surgery. If a biopsy or an excision is performed on a particular lesion or lesions, this would necessitate that the tissue removed be examined. This falls under a surgical pathology category and is billed separately.

-If surgical time is scheduled for you, we ask that we receive at least 24 hours notice for any cancellation as time has been reserved on your behalf. We do reserve the right to charge a $100.00 prorated fee if prior notice is not given.
-Pathology specimens are sometimes sent out for secondary opinions. This does incur a separate fee for the outside consultation and can also be billed to your insurance carrier.
-An office consultation fee and a separate surgical procedure fee may also be charged if a medical condition as well as a separate surgical condition is treated on the same date of service.
**Please be aware that insurance benefits vary from plan to plan. Some insurance plans sometimes carry higher surgical deductibles and co-pays for procedures such as liquid nitrogen therapy, biopsies, pathologies, and other surgical interventions.*

INSURANCE BILLING:
We are pleased to bill your insurance for any non-cosmetic services provided we are presented with a current insurance card. Otherwise, payment is expected at the time services are rendered. Co-pays are due at the time of service.
*Please note that proof of eligibility, covered and non-covered services and various exclusions cannot be determined until your carrier processes the claim. Therefore, we do submit insurance claims with the understanding that you are responsible for any non-covered services as well as co-payments and deductibles.
*We accept cash, checks, Visa, Master card, American Express, Discover and ATM debit cards for your convenience.

COSMETIC MEDICAL SERVICES POLICY:
Our office does offer cosmetic services. This includes laser procedures, chemical peels, procedures to treat leg veins and spider veins, BOTOX®, Restylane®, Juvederm® or Dysport® injections as well as Latisse and other cosmetic medications.
We offer these services to patients who are good medical candidates. In the event you do schedule time for any of these elective services, we do ask you to come prepared to pay for these procedures at the time of service. We do not bill insurance for these services and we do not accept financial arrangements for cosmetic procedures or medications.

We hope this information has been helpful. Please do not hesitate to call our billing department with any questions.

Please sign below that you have read and understand the contents of this form.

_____ _____
Patient or representative signature Date