The Dermatology Center at Ladera - Financial Agreement

"Dedicated to Skin Health and Quality Patient Care"

Patient Information:

_____ _____ / _____ / _____

Patient Name (first, middle initial, last) Date of Birth: month day year

Patient's Insurance Information: ☐ **Or, Check Here if Self-Pay** (e.g., no insurance, HMO benefits only, Kaiser, etc.)

Primary Insurance Co.:_____ Subscriber Number/ID#: _____

_____ _____ _____ _____

Insurance Subscriber Name (if **not** the patient) Relationship to Patient Insurance Subscriber Date of Birth Insurance Subscriber Social Security

Supplemental or **Secondary** Ins. Co.:_____ Subscriber Number/ID#: _____

_____ _____ _____ _____

Insurance Subscriber Name (if **not** the patient) Relationship to Patient Insurance Subscriber Date of Birth Insurance Subscriber Social Security

Our Policies, and Patient's (or Parent/Guardian's) Responsibilities

☐ Initial here

Patients must understand *their own* network, plan benefits, and plan limitations. Your health insurance is an agreement between you and your insurance. All charges are ultimately your responsibility, whether you have insurance or not. Not all services are covered under all plans, regardless of whether our doctors consider the care medically necessary. Because there are so many plans, it is not possible for us to know the specific details of your coverage. By making a copy of your card, it does not confirm that we are part of your Network. We always do our best, but failure of our office staff to identify out-of-network plans does not waive your responsibility for payment of services rendered.

We are In-Network with most traditional PPO plans. Our current and best understanding of our network participation is on our website, but **we are out-of-network with:** United Healthcare PPO, all HMOs, most State Exchange plans, most Narrow PPOs, all HMO/IPA plans, Medicare Advantage HMOs, Medicaid/Medi-Cal/CalOptima, Worker's Compensation plans, and most Blue Shield and Anthem Blue Cross individual/family plans purchased outside of employer group plans. Our recommendation is to call your insurance about a week before your appointment and ask if your plan's network includes your doctor at our office, and what patient cost-sharing may be applied. You authorize your insurance to pay us directly.

☐ Initial here

Bring patient's Insurance Card to every visit. Patients with insurance are responsible for ensuring that our insurance records and other information are up to date. Patients who have not presented a valid, active insurance card will be considered self-pay/cash-pay – and they must pay a minimum of $50 visit fee at arrival. Patients will have full responsibility for charges if we cannot process a claim due to incomplete, inaccurate or obsolete information. If your insurance changes, you must notify us immediately (even if you do not yet have your card); delays caused by patients can result in the claim being uncollectible from insurance, resulting in patient having full responsibility for all charges.

☐ Initial here

Co-Pay, Self-Pay, and Cosmetic services are due at the time of service. Co-pay is always expected at date of service. We are obligated to collect the full patient cost sharing including the co-pay, co-insurance, and deductible; it is our policy and practice to do so. There is a $5 billing fee for all Co-Payments that must be billed after the date of service. For patients with high deductible plans, a $50 payment will be collected on date of service towards the office visit. In some cases, we will ask for additional payment towards coinsurance or deductible prior to treatment. Our office will not bill "preventative" visits.

☐ Initial here

All procedures and lab services have fees, in addition to the visit fee. Co-pay is usually for office visit only, and does not typically cover procedures (e.g., any type of freeze, removal, incision, injection, or other treatment). There are no guarantees that procedures will work, multiple treatments are sometimes required, and each treatment has separate fees. Estimates for medical procedures are not typically given by the doctor; estimates can be provided, but procedures will typically need to be rescheduled for another day. Any skin growth that is removed must be treated as if it could be cancerous, even if it is removed primarily at the patient's request, and will result in both biopsy and pathology fees. Labs, imaging, special stains, and other tests sometimes must be ordered, and may be furnished by independent sources to complete a diagnosis. We are not responsible for those charges; contact those facilities for billing questions. Visits that are prolonged, some phone calls with physicians, or virtual visits may be billed. Cosmetic consults usually become regular medical visits, and have standard medical office visit fees; if a patient wants a visit to discuss treatments for wrinkles only (e.g., botox or filler only), the consult fee is $125. Cosmetic procedures that need extra time require a $100 deposit.

☐ Initial here

Bills are due upon receipt. We are required to collect co-pay, deductible, and co-insurance. Past due balances will be assessed a $10 statement fee for each additional statement we must send. Any self-pay, out-of-network, or other courtesy adjustments will be rescinded if account becomes over 30 days past due. We may charge 18% interest or as allowed by law for any delinquent payment. We exhaust efforts to resolve balances prior to use of a collection agency; however, additional fees up to 50% of your charges may accrue from collections activity. Returned checks will be assessed a $25 fee.

☐ Initial here

Appointment Cancellation Fees. We make numerous efforts to remind you of appointments. Out of courtesy to other patients that need appointments, please notify us if you need to cancel at least one full business day prior. To encourage early notice, the following fees will apply for late cancellation or no-show: $50 for a regular appointment and $100 for medical procedure, surgery, or cosmetic procedures.

☐ Initial here

Your health information is protected. We must release patient health information for treatment, payment or healthcare operations (e.g., to pharmacies, labs, insurance, other physicians, etc.) Any other release requires your written consent. Our Notice of Privacy Practices is available to you. We may leave a detailed message on your home or cell phone, with health information. We may access your history of medications that were prescribed by other providers.

List any others with whom we can discuss the patient's care/emergencies/finances in detail (e.g., spouse, parent, child, etc):

Name of Health Contact	Relationship to patient	Primary Phone#
Name of Health Contact	Relationship to patient	Primary Phone#

Agreement by Patient (or Parent/Guardian). I have read each policy, I understand them, and I agree.

Signature of Patient (or Parent/Guardian) _____ Date _____

Printed Name _____ Date of Birth _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Cell Phone Number _____ Home Phone Number _____ Work Phone Number _____ X _____ Email (***please PRINT CLEARLY***) _____

Thank you for taking the time to understand our policies. Our mission is to provide high quality care. Insurance details can be challenging – please contact our billing team at (949) 207-3182 with questions.

THE DERMATOLOGY CENTER at Ladera

MEDICAL QUESTIONNAIRE

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

Reason for Visit:_____

Do you have or have had any of the following? *(if yes, please check)*

- ❑ Acne
- ❑ Actinic Keratosis
- ❑ Artificial heart valve
- ❑ Artificial joints or metal implant
- ❑ Atopic Dermatitis
- ❑ Atrial Fibrillation
- ❑ Atypical moles
- ❑ Autoimmune disease (lupus, rheumatoid arthritis)
- ❑ Bleeding disorder
- ❑ Blood clots
- ❑ Chronic Fatigue/Fibromyalgia
- ❑ Cold sores/herpes
- ❑ Depression
- ❑ Diabetes
- ❑ Down's Syndrome
- ❑ Heartburn/Ulcers/ Gastritis/Reflux
- ❑ Heart disease
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV
- ❑ Keloids or scarring problems
- ❑ Kidney disease
- ❑ Liver disease or hepatitis
- ❑ Lung disease
- ❑ Melanoma
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Psoriasis
- ❑ Reactions to local anesthesia
- ❑ Seasonal allergies/asthma
- ❑ Seizures
- ❑ Stroke
- ❑ Skin Cancer (basal or squamous cell carcinoma)
- ❑ Cancer, other Please list:
- ❑ Thyroid trouble
- ❑ Other conditions Please list:

Please list any medications, herbal supplements and/or vitamins you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? ❑ Yes ❑ No *(if yes, please list medication and reaction)*

Medication:_____ Reaction:_____ Medication:_____ Reaction:_____

Medication:_____ Reaction:_____ Medication:_____ Reaction:_____

Please list major surgeries:

_____ Date:_____ _____ Date:_____

_____ Date:_____ _____ Date:_____

_____ Date:_____ _____ Date:_____

Please list major hospitalizations:

_____ Date:_____ _____ Date:_____

_____ Date:_____ _____ Date:_____

Name:_____

Please list any relatives (mother, father, grandmother, grandfather, brother, sister) **that have had any of the following conditions?**

- ❑ Melanoma: _____
- ❑ Skin Cancer:_____
- ❑ Cancer, Other: _____
- ❑ Diabetes: _____
- ❑ Hypertension: _____
- ❑ Other: _____
- ❑ Elevated Cholesterol: _____
- ❑ Heart Disease:_____
- ❑ Stroke:_____
- ❑ Mental Illness: _____
- ❑ Unknown:_____

How many do you have of the following? Brothers: _____ Sisters: ____ Sons: _____ Daughters: ____

Do you exercise?	❑ Yes	❑ No	
Do you need antibiotics before surgery or dental work?	❑ Yes	❑ No	
Do you take aspirin or are you on blood thinners?	❑ Yes	❑ No	
Do you have any Hepatitis A, B, C exposure?	❑ Yes	❑ No	
Do you have any HIV exposure?	❑ Yes	❑ No	
Do you have any IV drug use history?	❑ Yes	❑ No	
Do you smoke tobacco? See questions below.	❑ Yes	❑ No	
Do you drink alcoholic beverages?	❑ Yes	❑ No	If yes, number of beverages/week? _____
Travel Outside of the US?	❑ Yes	❑ No	

What is your occupation? _____

Tobacco Use *(please check one category)*

❑ Never a smoker.

❑ Former smoker. If Yes, how long has it been since you last smoked? *(please check one)*

❑ <1 month ❑ 1-3 months ❑ 3-6 months ❑ 6-12 months ❑ 1-5 years ❑ 5-10 years ❑ >10 years

❑ Current smoker. If Yes:

How often do you smoke Cigarettes? *(please check one)*

❑ every day ❑ some days, but not every day

How many cigarettes a day do you smoke? *(please check one)*

❑ 5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 ❑ 31 or more

How soon after you wake up do you smoke your first cigarette? *(please check one)*

❑ within 5 min ❑ 6-30 min ❑ 31-60 min ❑ after 60 min

Are you interested in quitting? *(please check one)*

❑ Ready to quit ❑ Thinking about quitting ❑ Not ready to quit

Have you recently had any of the following? (*Please check all that apply)*

❑ Weight change	❑ Fatigue	❑ Diarrhea	❑ Neck stiffness
❑ Fever	❑ Heat/Cold Intolerance	❑ Constipation	❑ Headache
❑ Chills	❑ Irregular Menstrual Cycles	❑ Vomiting	❑ Seizures
❑ Change in hair pattern	❑ Sore Throat	❑ Swollen Glands	❑ Vision changes
❑ Chest pain	❑ Cough	❑ Easy bruising	❑ Depression
❑ Palpitations	❑ Ringing in Ears	❑ Abnormal bleeding	❑ Nervousness
❑ Leg Swelling	❑ Recurrent Nosebleeds	❑ Joint pain	❑ Blood in urine
❑ Shortness of breath	❑ Nausea	❑ Muscle aches	

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ADDITIONAL PATIENT INFORMATION

Name: _____ **Date of Birth:** _____
Last *First* *M.I.*

Gender: ❑ M ❑ F

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated

If Married, name of spouse: _____

Patient Race: ❑ White ❑ Hispanic ❑ Asian ❑ Black or African American ❑ American Indian or Alaska Native ❑ Native Hawaiian ❑ Other Pacific Islander ❑ Other Race

Ethnicity: ❑ Hispanic ❑ Non-Hispanic **Preferred Language:** ❑ English ❑ Spanish ❑ Other: _____

Primary Care Physician: _____ **Phone:** _____ **Location:** _____

Referring Physician: _____ **Phone:**_____ **Location:** _____

Pharmacy Name & Location: _____

Employment Status: ❑ Full Time ❑ Part-Time ❑ Self-Employed ❑ Retired ❑ Not employed ❑ Student

Employer Name: _____ **Work Phone: ( ) - ext:** _____

Employer Address: _____
Street *City* *State* *Zip*

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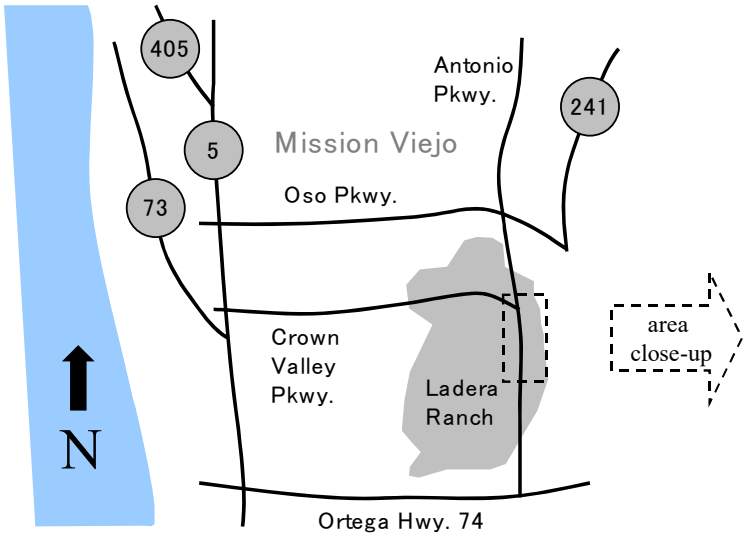
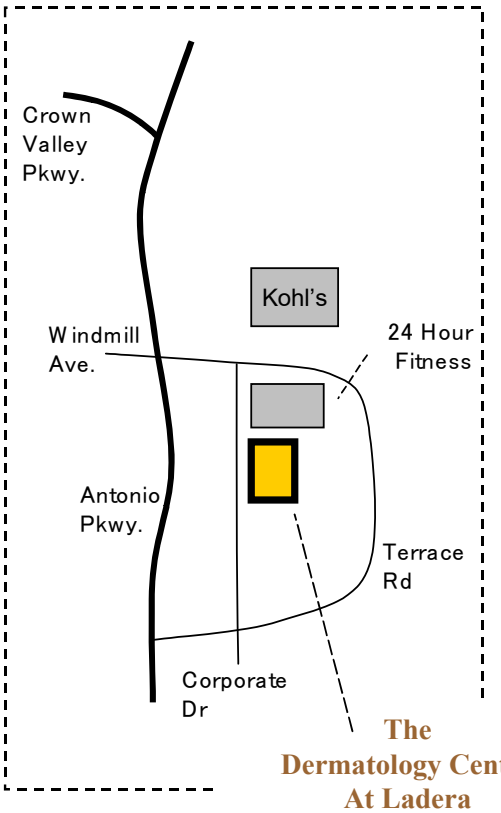
Driving Directions from Interstate 5:

Exit Crown Valley Parkway away from the ocean (east)
Right on Antonio Parkway (south)
Left on Windmill Ave (east)
Right on Corporate Drive (south)
2nd Building on the left is 600 Corporate Drive
600 Corporate Drive, Suite 240





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