

The Dermatology Center at Ladera – Financial and Care Consent Agreement

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. It is not possible for us to know all the specific details of your coverage. You accept responsibility for payment if your insurance denies coverage for any reason. 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 full network/traditional PPO plans. Our 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 Network 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

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 visits often turn into 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

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 payment towards coinsurance or deductible prior to treatment. Our office will not bill "preventative" visits.

Initial here

Patients are Partners in their care. Patients are responsible for scheduling follow-up skin checks and procedures, keeping follow-up appointments and rescheduling missed appointments, calling the office if they do not hear the results of biopsies, labs and other tests, informing their doctor if they decide not to follow the recommended treatment plan, etc.

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 referral to a collection agency; however, additional fees of 50% of your charges or more may accrue from collections activity, and the patient and their family may be discharged from the practice. 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. I consent to 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. I have read each policy, I understand them, and I agree.

Consent to Treatment. I hereby consent and authorize The Dermatology Center at Ladera and its Affiliated Providers to perform medical care, diagnostic tests, surgical care, and other therapeutic measures as indicated for my health. If I will not comply with the medical program of care provided or recommended, I understand that thereupon I relieve my physician(s), healthcare provider(s), medical staff, and the company, of all responsibility resulting from my action.

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**)

MEDICAL QUESTIONNAIRE

Patient Name: _____

Date of Birth: _____

Reason for Visit: _____

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

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

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?**

- | | |
|---|--|
| <input type="checkbox"/> Melanoma: _____ | <input type="checkbox"/> Elevated Cholesterol: _____ |
| <input type="checkbox"/> Skin Cancer: _____ | <input type="checkbox"/> Heart Disease: _____ |
| <input type="checkbox"/> Cancer, Other: _____ | <input type="checkbox"/> Stroke: _____ |
| <input type="checkbox"/> Diabetes: _____ | <input type="checkbox"/> Mental Illness: _____ |
| <input type="checkbox"/> Hypertension: _____ | <input type="checkbox"/> Unknown: _____ |
| <input type="checkbox"/> Other: _____ | |

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

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

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

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: American Indian or Alaska Native Asian Asian Indian Black or African American Decline to Specify
 Native Hawaiian Other Pacific Islander Other Race White

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

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

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

Pharmacy Name & Location: _____

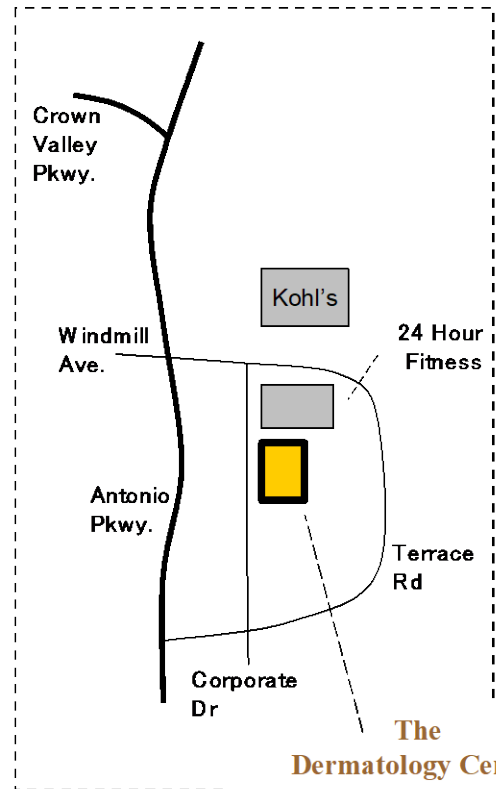
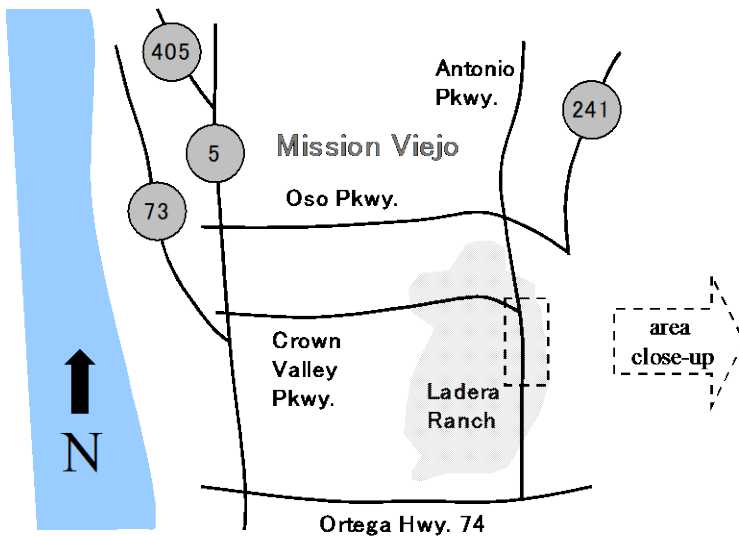
Employment Status: Full Time Part-Time Self-Employed Retired Not employed Student

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

Employer Address: _____
Street City State Zip

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



**The
Dermatology Center
At Ladera
600 Corporate Dr.
Suite 240
(949) 364-8411**