THE DERMATOLOGY CENTER at Ladera

Financial and Care Consent Agreement

Patient Information:

_____ _____

***Patient** Name (first, middle initial, last)* *Date of Birth (MM/DD/YYYY)*

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

☐ Initial here **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.

☐ 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.
Emergency contact is defined as any person with whom we can discuss the patient's care/emergencies/finances in detail (e.g., spouse, parent, child, etc.).

☐ 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. 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 often 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 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, pathology consult, 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. Additional fees may apply per industry standards for phone/virtual/televisit/portal visits, prolonged visits, follow-ups or complications after treatment, some coordination with other providers, or otherwise special care.
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 $200. 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. There is a $5 billing fee for all Co-Payments that must be billed after the date of service. 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 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. 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.

Agreement. I have read each policy, I understand them, and I agree.

✘ _____ _____

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

_____ _____

*Printed Name of Patient **(or Parent/Guardian)*** *Date of Birth (MM/DD/YYYY)*

THE DERMATOLOGY CENTER at Ladera

MEDICAL QUESTIONNAIRE

Patient Name:_____ **Date of Birth:**_____
Last *First* *M.I.* *MM/DD/YYYY*

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:_____

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:_____ Daughters:_____ Sons:_____

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	

THE DERMATOLOGY CENTER at Ladera

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____
Last First M.I. *MM/DD/YYYY*

Mailing Address: _____
Street Address City State Zip

Cell Phone No.: _____ **Home Phone No.:** _____ **Work Phone No:** _____

Email Address: _____
(PLEASE PRINT CLEARLY)

Birth Sex: ❑ Female ❑ Male

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

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 ❑ Decline to Specify ❑ Non-Hispanic

Preferred Language: ❑ English ❑ Spanish ❑ Other: _____

If patient is a minor: _____ _____ _____
Parent/Guardian Name *Relationship to Patient* *Parent/Guardian's Date of Birth*

Emergency/Health contact is a person whom we can discuss the patient's care/emergencies/finances in detail (e.g., spouse, parent, child, etc.):

_____ _____ _____
Emergency/Health Contact Name *Relationship to Patient* *Phone Number*

_____ _____ _____
Emergency/Health Contact Name *Relationship to Patient* *Phone Number*

Primary Care Physician: _____ _____
PCP Name *PCP Phone Number*

Pharmacy Name & Location: _____ _____
Pharmacy Name *Pharmacy Address*

INSURANCE INFORMATION

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* *Subscriber's Date of Birth*

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

_____ _____ _____
*Insurance Subscriber Name (if **not** the patient)* *Relationship to Patient* *Subscriber's Date of Birth*