

NEWPORT COAST DERMATOLOGY MEDICAL HISTORY

Patient Name: _____ Date: _____

Are you allergic to any medications? Yes No, If yes, list below:

Have you ever had dental anesthesia? Yes No Any bad reaction? Yes No

Date of last dental exam: _____

List all medications you are currently taking (including prescriptions, over-the-counter meds including aspirin, herbals, vitamins):

Do you take any blood thinners like aspirin, coumadin, plavix, motrin, Vitamin E? Yes No

Do you have or have you ever had any diseases or conditions of: (Please Check YES or NO)

	YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Disease	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Valves	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Cancer: Type? _____	<input type="checkbox"/>	<input type="checkbox"/>			

List any other conditions: _____

List any major surgeries: _____

(Women) Are you currently pregnant or nursing? Yes No

Have you ever had any skin cancer? Yes No explain: _____

Has any blood relative had any skin cancer? Yes No explain: _____

Do you have a history of any skin diseases? Yes No explain: _____

Do you have any problems with healing? Yes No explain: _____

Do you keloid or scar easily? Yes No explain: _____

SOCIAL HISTORY:

Do you drink alcohol? Yes No If Yes _____ drinks per day week

Do you use IV drugs? Yes No If Yes, what? _____

Do you smoke? Yes No If Yes, how much: _____

Have you had or been exposed to HIV/ AIDS? Yes No

What is your current occupation? _____

What are your current hobbies? _____

Completed by Patient Signature: _____ Date: _____

Medical Assistant _____ Reviewed By: _____ Date: _____

Initials

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy of contacting our office.

You have the right to request that we restrict how protected health information about you is used for disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

I understand that:

The Practice has permission to call or contact and/or their responsible financial guarantor for treatment, payment, or health care operations. The Practice Policies include generally confirming patient appointments via phone or leaving messages on voicemail or answering machines. The Practices may call or contact patients for test, biopsy, other lab results, follow-ups, and visit reminders. In case of medical emergency or need for urgent contact, listed patient emergency contacts may be contacted. To ensure safety of patients and staff, the Practice has a 24 hour security system and premises video monitoring system and policy in place.

This Consent was signed by:

 Print Name – Patient or Representative

 Signature

____/____/____
 Date

Relationship to Patient
(if other than patient): _____

Witness: _____

 Staff signature

____/____/____
 Date

NEWPORT COAST DERMATOLOGY PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

We understand that you have a choice in healthcare and we thank you for choosing us to serve you and your family’s skin care needs. We are committed to providing you with the best possible care, and we are pleased to discuss professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility. You may ask for an estimate of your charges before a procedure is performed. Please note that all procedures have additional costs and are not included in a regular office visit fee. (Freezing, “burning-off”, skin tag removal, laser, acne surgery/slush, peels, biopsies, surgeries, injections, cyst drainage, mole or wart removal, etc.)

INSURANCE (Please check with your carrier before your visit to confirm coverage.) I understand that it is my responsibility to know my insurance plan and to verify coverage for referrals to other doctors, recommended tests and laboratories. I understand that there are numerous insurance companies, even more individual health plans and very variable benefits. My doctor’s office does not know my individual plan and is not authorized to make any guarantees regarding individual insurance coverage.

PPO INSURANCE: We are providers of most PPO plans. Newport Coast Dermatology has preferred provider contracts with several insurances including Blue Cross, Blue Shield, Aetna, Pacificare, Cigna, United Healthcare, HealthNet, PHCS, CCN, and Beechstreet. One insurance carrier is billed in courtesy for me. I may choose to self-bill any secondary insurance plans. (EPO plans require a credit card guarantee.)

MEDICARE: We accept straight Medicare (NO HMOS OR RAILROAD MEDICARE). Please note Federal Law mandates Medicare’s annual \$165 deductible.

MEDI-CAL/CAL-OPTIMA: We are NOT providers of any state plans nor can we accept anyone with Medi-Cal.

HMO INSURANCE/MONARCH HMO: We do not have any HMO contracts. . If you should decide to be seen outside of your plan, your visit will be considered self-pay and full payment for all services is due at the time of your visit.

CO-PAYS: I understand that insurance plans legally and contractually obligate all health care providers to collect my set co-pay at each and every visit. (Please note and be prepared to pay your co-pay due at check-in, before your visit.)

DEDUCTIBLES & CO-INSURANCE: We will bill your insurance carrier but you will receive a statement from us regarding any deductibles or co-insurance that your insurance company has deemed your responsibility as designated on your explanation of benefits.

LAB TEST AND PATHOLOGY CHARGES: If my visit includes biopsies, lab tests, or cultures, I understand that I will receive separate billings from the company performing these outside services for me. All biopsies and surgeries result in a specimen being sent to pathology for examination, and therefore will be additional charges. If any pathology specimen requires a second opinion, the consulting lab will bill your insurance separately.

UNPAID ACCOUNTS: Accounts not cleared in a timely fashion will accrue a minimal late fee of \$15 per unpaid statement cycle/month. Unpaid accounts in bad standing are sent to collections which will result in further costs including late fees, collections fees, legal fees, and may cause an adverse incident on my credit report. Returned bad checks require a \$35 fee. Unpaid bad checks are referred to The Orange County District Attorney for legal remedy.

COSMETIC SERVICES: Facial peels, lasers, collagen, Restylane, and Botox injections are among the many cosmetic/insurance NON-covered services. These are strictly self-pay/cash basis and are paid immediately at the time of the procedure. Newport Coast Dermatology is not permitted to bill any cosmetic services to patients or insurance.

SPECIAL NOTE: I understand that insurance is a special contract between me and my insurance company. I understand that Newport Coast Dermatology is not a party to this contract and has no authority to become involved in insurance carrier disputes other than to supply factual information as necessary. I understand that if my insurance is not effective, if my insurance refuses coverage for what they deem “not medically necessary”, or if my insurance demands a refund on a previously paid claim, I will need to pay for all medical services performed. I understand that I am always ultimately responsible for medical services which I choose to receive, and the timely payment of my account. I have read and understand the above information.

Patient or Responsible Party Signature: _____ **Date:** _____

PAYMENT POLICY:

Medicare: We are participating providers of straight Medicare **BUT NOT HMOS OR RAILROAD MEDICARE.** We will accept assignment on all claims. Patients are responsible for meeting their annual \$135.00 deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed the balance.

PPO: You will be responsible for paying your annual deductible if not met and co-payments at time of service.

COMMERCIAL PATIENTS: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 100% of the total bill at the time of the service. We will give you a copy of your bill to submit to your insurance for reimbursement.

Patient or Responsible Party Signature: _____ **Date:** _____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card: _____ **Date:** _____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically “crosses over”, we are required to keep a separate signature on file. I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Medigap Card: _____ **Date:** _____

NEWPORT COAST DERMATOLOGY

PATIENT PARTNERSHIP PLAN

Dear Patient,

Welcome to Newport Coast Dermatology. We intend to provide you with the care and service that you expect and deserve. Achieving your **best possible health** requires a “partnership” between you and your doctor. As our “partner in health,” we ask you to help us in the following way:

• **Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings.**
I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc.). **These health screenings are tests that can help detect life-threatening diseases and conditions.** If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

• **Keep Follow-up Appointments and Reschedule Missed Appointments**
I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her the chance to check my condition and response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

• **Communication with the Office and Patient Privacy Agreement**
To ensure patient HIPAA privacy laws and optimal speedy communication, I agree to communicate any questions or concerns via phone, secure fax, or in writing. I agree to the mutual privacy agreement and authorize the office to retain full copyrights to any communication or online posts related to my treatment and services.

• **Call the Office When I Do Not Hear the Results of Labs and Other Tests**
I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

• **Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan**
I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and test, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

• **I agree not to share any prescriptions written by any practitioners in this office with other people.**
I understand that all prescriptions are written specifically for my medical condition and should not be shared with other people since they have not been medically evaluated for possible side-effects or drug interactions.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, **at any time**, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

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 of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in 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 relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both 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 of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall elect 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, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to 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 Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators 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 one 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 of 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 signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

Patient or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or 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: Newport Coast Dermatology
Coastal Image Dental
And its Affiliated Partners

(Date)

By: _____
(Patient's or Patient Representative's Signature) (Date)

By: _____
(Print Patient's Name)

(If Representative, Print Name and Relationship To Patient)

(PHYSICIAN COPY)

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By: Newport Coast Dermatology
Coastal Image Dental
And its Affiliated Partners

(Date)

By: _____
(Patient's or Patient Representative's Signature) (Date)

By: _____
(Print Patient's Name)

(If Representative, Print Name and Relationship To Patient)

(PATIENT COPY)