Comprehensive Dermatology Group
PEDIATRIC & ADULT SPECIALISTS

ADULT PATIENT INFORMATION

781 Garden View Ct., Suite 201, Encinitas, CA 92024
Phone 760 634 3376 Fax 760 634 7955

PLEASE PRINT AND COMPLETE BOTH SIDES

Date: _____

Patient Name: ____ _____
Title Last First MI

Nickname: _____ **Spouse Name:** _____

DOB: _____/_____/_____ **Age:** _____ **Gender:** Male Female

Transgender: Male/man (FTM) Female/woman (MTF) Nonbinary Prefer not to say/other

Home Address: _____
Street City State Zip

Mailing Address: _____
(If different from above) Street City State Zip

Phone: (_____) _____ (_____) _____ (____)_____
Home Cell Work

Employer's Name: _____**Occupation:**_____

Best place to leave message, including confidential information: (____) _____

Email: _____

INSURANCE INFORMATION

Primary Insurance Co: _____

Name of Insured: _____

Your relationship to insured: **Self** **Spouse** **Parent**

Member ID #:_____ _____**Group #:**_____

Secondary Insurance Co: _____

Name of Insured:_____

Your relationship to insured: **Self** **Spouse** **Parent**

Member ID #:_____ **Group #:**_____

PLEASE COMPLETE FRONT AND BACK

Modified: 01/06/2012

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ADULT PATIENT INFORMATION

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship to patient: _____

Phone: (_____)_____ (_____)_____ (_____)_____
Home Cell Work

REFERRAL INFORMATION

Name of physician or friend that referred you: _____

Referring physician phone number: (_____)_____

Primary Care Physician: _____

Primary Care phone number: (_____)_____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between you, your employer and the insurance company. **Not all services are covered by all contracts.** We participate and accept assignment from most major payers, which means covered charges, will be paid directly to us. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received payment from your insurance carrier. If we do not participate in your insurance plan, you may still choose to be seen in our practice as a "SELF PAY" patient. Our physicians offer a discounted "SELF PAY" rate that is due at time of service.

SUNSHINE ACT

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov. For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Your Signature: _____ Date: _____

PLEASE COMPLETE FRONT AND BACK

Comprehensive Dermatology Group
PEDIATRIC & ADULT SPECIALISTS

PATIENT MEDICAL HISTORY FORM

Date: _____

Name: _____ **DOB:** _____

Reason for Visit: _____

_____

Allergies: _____

Current Medications (include prescriptions, over-the counter, vitamins, herbals):

Medication	Dose	Frequency	When started

Major Medical Illnesses/Surgeries: _____

_____

_____

_____

Females: Are you pregnant? ____Yes _____No If Yes, when due _____
Are you planning to become pregnant? _____Yes _____No
Are you nursing? _____Yes _____No

PLEASE COMPLETE FRONT AND BACK

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Past Medical History/ Family History: Check if you or anyone in your family has:

	Self	Relative		Self	Relative		Self
Skin Cancer			Arthritis			HIV	
Melanoma			Autoimmune Disease			Hepatitis B or C	
Other Cancer			Bleeding disorder			Tuberculosis	
Eczema			Diabetes			Positive tb test (ppd)	
Psoriasis			Gastric Ulcer				
Keloids			High Blood Pressure				
			Thyroid Disease				

Current or Past Medical Problems With:

	Yes	No	If yes, please explain
General Health			
Allergy/Immunologic			
Eyes			
Ears/Nose/Mouth/Throat			
Heart			
Lungs			
Stomach/Gastrointestinal			
Kidneys/ Bladder			
Joints/ Arthritis/ Musculoskeletal			
Blood/ Bleeding Problems			
Blood Clot			
Neurological/ Headaches/ Seizure			
Psychiatric			
Other			

Social History:

Sexual Orientation: Heterosexual (Straight) Homosexual (Gay, Lesbian) Bisexual Prefer not to say/Other

Do you drink alcohol?____Yes ____No If yes, drinks per day _____
Do you smoke? ____Yes ____No If yes, packs per day _____
If quit, what year _____
Have you ever used IV drugs? ____Yes ____No
Hobby/Leisure Activities: _____

Patient Signature: _____ Date: _____

PLEASE COMPLETE FRONT AND BACK

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PEDIATRIC & ADULT SPECIALISTS

Patient Name: _____ DOB: _____

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Under HIPAA requirements, we are not allowed to give any of your health information to anyone else without your consent. Please sign below if you wish to have us leave or discuss information regarding your appointment, test results, or procedures with a member of your family. Signing this form will only allow us to discuss appointment information, test results, and procedure information with the persons listed below.

I authorize Comprehensive Dermatology Group to release appointment information, test results, and procedure information to the following individuals:

1. _____ Relation to patient: _____

2. _____ Relation to patient: _____

Patient Signature: _____ Date: _____

AUTHORIZATION TO LEAVE A MESSAGE ON ANSWERING MACHINE

Under HIPAA requirements, we are not allowed to give any of your health information to anyone else without your consent. Please sign below if you wish to have us leave information regarding your appointment, test results, or procedures on a voicemail or answering machine. Signing this form will only allow us to leave appointment information, test results, and procedures information on the phone numbers listed below.

I authorize Comprehensive Dermatology Group to leave a message regarding appointment information, test results, or procedure information on the following answering machines/ voicemails.

1. (_____)_____

2. (_____)_____

3. (_____)_____

Patient Signature: _____ Date: _____

Comprehensive Dermatology Group
Pediatric and Adult Specialists

Office Policy

1. **Missed Appointments:**
    - We require at least 24 business hours if you need to reschedule or cancel an appointment. A $50 charge will be applied for appointments that are not cancelled in this time frame. 48 business hours are required to cancel a surgical procedure.
    - A $100 charge ($200 charge for Mohs surgery) will be applied for surgical no shows or reschedules under the 48-business hour window.
    - Please **Do Not** rely on our automated reminder service as your only reminder to keep your scheduled appointment, as we cannot guarantee this service or that the phone number provided is accurate and functional for this purpose.
    - Please **Do Not** reply on text reminders. You must call our office to cancel your appointment.

2. **Co-Payments and Deductibles:**
    - Co-pays are due at the time of check-in for your appointment. Our office accepts credit (Visa – Master Cards) and debit cards only. We do not accept cash or checks.

3. **Insurance Cards:**
    - Please provide us with your insurance card. If you are unable to provide your insurance card, we will gladly see you as a **"Self-Pay Patient".** Then, you may submit the claim to your insurance for reimbursement.

4. **Insurance Policies:**
    - As a courtesy, we will bill your primary and secondary insurance companies. However, you are ultimately responsible for payment of services not covered by your insurance plan. It is your responsibility to call and check with your insurance as to which services are covered.

5. **Out-Of-Network:**
    - It is your responsibility to make sure Comprehensive Dermatology Group is in network with your plan. If you have out-of-network benefits, we will bill your insurance as a courtesy. Please note that you will be responsible for any remaining balance.

6. **Cosmetic Services:**
    - Cosmetic services must be paid at the time of your visit. These services cannot be billed to your insurance. Cosmetic services include, but are not limited to: skin tag removal, benign growth removal, Botox, filler, peels, and laser treatments.

7. **Minor Patients:**
    - The adult accompanying a minor and the minor's parents or guardians are responsible for full payment for services rendered. Comprehensive Dermatology Group is **NOT** a party to any divorce decree. Financial responsibility for minor receiving medical services rests with accompanying adult.

8. **Collections:**
    - Comprehensive Dermatology Group will send you a statement after your insurer have been billed. If you have not received one 30 days after your visit, please contact our office. Once you receive the statement, you have 30 days from the date on the statement to dispute or pay the charges. We will charge a late fee on all outstanding balances after 30 days. If no payment is received after 120 days, your account may be turned to a collection agency.

By signing below, you agree that you received, understand and will abide by the described office policy: Thank you.

_____

Print Name

_____ _____

Signature Date

We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

PLEASE SIGN BELOW

I, _____ hereby, acknowledge receipts of the Notice of Privacy Practices given to me.

Sign: _____

Date: _____

If not signed, reason why acknowledgement was not obtained: