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

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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

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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

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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

Modified: 01/06/2012

Comprehensive Dermatology Group

Office Policy

1. **Missed Appointments**:

   - We require at least 24 business hours if you need to reschedule or cancel a regular appointment. A $50 charge will be applied for appointments that are not cancelled in this time frame.
   - We require at least 48 business hours if you need to reschedule or cancel a surgical procedure. A $100 charge ($250 charge for Mohs surgery) will be applied for surgical no shows or reschedules under the 48-business hour window.
   - Dr. Gigler's missed appointment fees are $100 for 15-minute regular office visits, $150 for any 30-minute procedures/visits and $250 for Mohs surgery.
   - 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, patients are responsible to call their insurance to make sure Comprehensive Dermatology Group is in network with their plan and to check what services are/are not covered by their insurance plan. You are ultimately responsible for payment of services not covered by your insurance plan.

5. **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.

6. **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.

7. **Balances Due:**
   - 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.
   - If your account is sent to collections, you understand and agree that you will be responsible for paying the outstanding balance in full, including any additional fees or costs incurred due to the collection process like collections fees, interest on overdue balances, legal fees (if applicable).

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

_____
Print Name

_____
Signature

_____
Date

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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

A copy of the Notice of Privacy Practices (HIPPA) is available upon request; please ask one of the front office staff. We also have the current notice posted on our website at comprehensivederm.com.

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

Sign: _____ **Date: _____**

If not signed, reason why acknowledgement was not obtained: