Welcome

Dear Patient,

We are delighted to welcome you to Pure Dermatology and Cosmetic Center. This letter contains answers to some of the most commonly asked questions by patients joining our office.

Pure Dermatology is located at 500 Superior Ave, Suite 335 in Newport Beach. We are a full service dermatology practice providing medical, cosmetic, and surgical services to patients of all ages.

All new patients are asked to complete the Patient Registration, Financial Policy, Notice of Privacy Practices and Health History in full and provide them to the receptionist when checking in for your initial appointment. If you are unable to keep your appointment, please give at least 24 hours' notice as a courtesy to our other patients and staff.

For the benefit of our patients, we are contracted with several insurance carriers. You will want to check with your insurance company to find out if we are listed as providers within your particular network. As part of our contact with your insurance carrier, we are required to collect any co-pay(s) from you at the time of service. We also collect any unmet deductible and non-covered services at the time of service. Please come prepared with your co-pay, identification card, and insurance card.

If you have any questions or concerns, please call our office at 949-706-1469. We look forward to meeting you soon!

Sincerely,
The Staff of Pure Dermatology & Cosmetic Center

Patient Registration

Name (Last, First, MI): ____ ☐ Jr☐ Sr

Date of Birth:_______________ Sex: ☐M ☐F ☐ Married ☐ Divorced ☐ Single ☐Widowed

Address:____ Apt.#________________

City_________________________________ State:____________ Zip Code:______________

Email: ____

Employer Name:____

Address:____

Home Phone:__________________________ Cell Phone:_____________________________

How did you hear about our office? Check or explain: ☐Dr. _______________________

☐Insurance Plan ___________________ ☐ Family/Friend (name) ______________________

☐ Hospital ______________ ☐ Google ☐ Yelp ☐ Radio ☐ Other (please specify) ______________

INSURANCE INFORMATION – *Guarantor Information* – ☐ Check here if same as patient

Responsible Party:______________________________ Date of Birth:__________________

Address:____City:__________________________

State:_________ Zip Code:______________ Patient's Social Security #:__________________

Daytime Phone:______________________ Occupation:______________________________

Employer Name:______________________ Address:_________________________________

Primary Insurance – Insurance Company Name: ________________________________

Subscriber Name:________________________ Subscriber's Social Security #:_____________

Subscriber ID:________________ Group #:________________ Policy #:__________________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance (If applicable) – Insurance Company Name: _____________________

Subscriber Name:______________________ Subscriber's Social Security #:______________

Subscriber ID:_____________________ Group #:______________ Policy #:_______________

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

EMERGENCY CONTACT:

Name:________________ Relationship to patient:__________ Phone Number:_____________

Please identify any individual(s) with whom our staff can discuss your medical condition or bills *(optional).

1. ___________________________ ☐ Medical Information ☐ Billing information
2. ___________________________ ☐ Medical Information ☐ Billing information

TREATMENT CONSENT: I hereby give consent for medical treatment to the providers with Pure Dermatology to care for myself *or* I am duly authorized by the patient as his/her agent to give consent for such treatment.

Patient/Guardian Signature__________________________________ Date: ______________

Dermatology Medical History

Patient Name (Last, First, MI):_______________________________________ ☐ Jr. ☐ Sr

Pharmacy Name:____________________ Pharmacy Phone: ____________________
Pharmacy Address:____

Reason for today's visit (chief complaint):________________________________
How long have you had this problem? ____________________________________
What parts of your body are affected? ____________________________________
How does this problem bother you? (symptoms): ____________________________
What treatments have you received for this problem:_________________________
Is your problem (please check one of the following):
☐ Worsening? ☐ Stable? ☐ Improving? Explain:______________________________

Meaningful Use:
Preferred Language: ☐ English ☐ Spanish ☐ Other ☐ Decline
Race: ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Other Pacific Islander ☐ Other ☐ Decline
Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown ☐Decline

Women:
Are you pregnant? ☐ Yes ☐ No Do you plan to become pregnant soon? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Medications: (Please list all current medications)
____
____

Allergies: (Please list all allergies)
____
____

Alerts: (please check all that apply)

- ☐ Allergy to Adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotics
- ☐ Artificial heart valve
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Artificial joint replacement
- ☐ Pacemaker
- ☐ Require antibiotics prior to a surgical procedure
- ☐ Rapid heartbeat with epinephrine
- ☐ Are you pregnant or currently trying to get pregnant

History and Intake Form

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ High Cholesterol
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Thyroid Problems
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ **None**

Other Medical History not specified: ____

Past Surgical History: (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Mechanical Valve Replacement
- ☐ Biological Valve Replacement
- ☐ Heart Transplant
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Prostate Biopsy
- ☐ Prostate Removed: Prostate Cancer
- ☐ TURP: Prostate Removal
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removes (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries Removed: Cyst
- ☐ Spleen Removed
- ☐ **None**

Other Surgical History not specified: ____

Skin Disease History: (please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Melanoma
- ☐ **None**

Other Skin Disease History not specified: ____

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? ______________________________

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes, which relative(s)? _______________

Social History: (Please check all that apply)

Cigarette Smoking:

- ☐ Currently Smokes
- ☐ Never Smoked
- ☐ Former Smoker
- ☐

Alcohol Use:

- ☐ **None**
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

Other Skin Disease History not-specified: ____

Review of Systems: Are you currently experiencing any of the following?

- ☐ Problems with bleeding
- ☐ Frequent infections
- ☐ Problems with healing
- ☐ Problems with Scarring (hypertrophic or keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Heartburn/Indigestion
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Fever or Chills
- ☐ Night Sweats
- ☐ Unintentional Weight Loss
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Thyroid Problems
- ☐ Hormonal Changes/Problems
- ☐ Sore Throat
- ☐ Mouth ulcers
- ☐ Ringing in ears
- ☐ Blurry Vision
- ☐ Abdominal pain
- ☐ Bloody Stool
- ☐ Bloody Urine
- ☐ Problems with urination
- ☐ **None**
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Joint aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Back pain
- ☐ Ankle swelling
- ☐ Hands/fingers sensitive to cold
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Coughing up blood
- ☐ Anxiety
- ☐ Depression
- ☐ Dizziness
- ☐ Headaches
- ☐ Confusion
- ☐ Memory loss
- ☐ Numbness
- ☐ Loss of Consciousness
- ☐ Insomnia
- ☐ Seizures
- ☐ Diarrhea

Other symptoms not-specified: ____

Financial and Billing Policies

Thank you for choosing Pure Dermatology & Cosmetic Center. We are committed to providing excellent skin health care in a patient focused environment. We are contracted with several insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments, deductibles, and other provisions. If you have any questions, we encourage you to call your health plan's member services department. Their number should be listed on the back of your insurance card.

We will submit claims to your insurance company, because of this, we ask that you inform us if your personal or insurance information changes. The lack of current information may cause delays in care and make you personally responsible for the cost of the entire visit.

Insurance Clause: If your office visit precedes the effective date of your insurance coverage or is not covered by your insurance, you will be held responsible for all fees incurred as a result of your visit.

Co-payments, Deductibles, and Co-Insurance:

Co-payments are due at the time of your office visit. Under the terms of our contract with various insurance plans, we cannot waive any co-payments, deductibles, or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience, we accept cash, checks, all major credit cards, and Care Credit.

Deposits: For certain procedures not covered by insurance, you may be required to pay a deposit or pay for the service in full, prior to treatment.

Prior Authorization: Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, is pre- existing, or is not a covered service, you will be asked to pay prior to the time of service.

Patient Responsibility Balances:
All patient responsible balances must be paid in full upon receipt of your statement. You should have already received an explanation of benefits from your insurance carrier. By this time, at least 30 days have passed since your visit and payment of balance is your responsibility.

Financial Policies Continued

Who Can Discuss a Bill? Due to privacy concerns, our staff may only speak with the patient or the person designated in writing by the patient to receive or discuss the patient's bill(s). Please identify the individual with whom our staff can discuss your bills on page 1 of the patient registration form.

Assignment of Payment: I hereby authorize payment directly to Pure Dermatology of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

Outside Services: To provide the best care possible, Pure Dermatology & Cosmetic Center may send specimens to an outside source for processing. Examples of these services are pathology and laboratory testing. If we send specimens to an outside office, you will receive a separatebilling statement from the outside pathologist or laboratory. These charges will be in addition to those for services rendered by Pure Dermatology.

Release of Information: You hereby give consent to release to authorized persons financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

Cosmetic Procedures: Elective cosmetic procedures are not covered by insurance companies. You are financially responsible for all charges associated with elective, cosmetic and non-covered procedures. Patients who have a cosmetic consultation will receive credit in the amount of the consult toward their cosmetic procedure.

Late Charges and Other Fees:

- Accounts with balances over 90 days old are subject to late fees.
- Accounts referred to a collection agency may be subject to a $50.00 collection fee, attorney fees, and/or the percentage allowed under California state law.
- There is a $25.00 fee for all checks returned for NSF (non-sufficient funds).

*I have read, understand, and agree to the above Financial and Billing Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

*I authorize my insurance benefits to be paid directly to Pure Dermatology & Cosmetic Center.

*I authorize Pure Dermatology to release pertinent medical information to my insurance company when requested or when needed to obtain authorization for a procedure or to facilitate payment of a claim. I have given complete and accurate information and agree to inform Pure Dermatology of any changes regarding my personal billing information or my insurance billing information.

Patient/Guardian (if patient is a minor) Signature **Date**

Printed Patient Name **Date of Birth**

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires all medical records and other individually identifiable health information used or disclosed by us in any form (electronic, paper, verbally, etc.) to be kept confidential. HIPAA gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information. This notice serves to explain how we will maintain the privacy of your health information and how we may disclose your personal information.

The patient understands that we may use and disclose your medical records for the following purposes:

- Treatment for providing, coordinating, or managing health care and related services by one or more healthcare providers; Payment for such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities; Health Care Operation – includes the business aspects of running our practice, such as conducting quality assessments and improving activities, auditing function, cost management analysis, and customer service.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other state or federal record-keeping requirements.
- Unless you instruct us not to do so, we may contact you by phone, text, or email, to provide appointment reminds. The following use and disclosure of PHI will only be made pursuant to us receiving a written authorization from you: Most uses and disclosure of psychotherapy notes; Uses and disclosure of your PHI for marketing purposes. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:
The right to request restrictions on certain uses and disclosures of PHI including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. However, we are not required to honor a request restriction unless in limited circumstances. The right to reasonable requests to receive confidential communications of PHI by alternative means. The right to inspect and copy your PHI. The right to receive an accounting of disclosures of your PHI. The right to obtain a paper copy of this notice from us upon request. The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed. The right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Physician-Patient Arbitration Agreement: 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 right to have any such dispute decided in a court of law before a jury, and instead or accepting the use of arbitration.

It is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA regulations currently in effect. We reserve the right to change the terms of our policies and to make the new notice provision effective for all PHI that we maintain. I have read, understand, and agree to the above Notice of Privacy Practices and HIPAA regulations and Physician-Patient Arbitration Agreement.

Patient Signature: ________________________________ Date: ____________________

No Show/Appointment Cancellation Policy

Office Visits

If you are unable to keep your general dermatology or cosmetic appointment, we ask that you notify our office by phone at least 24 hours in advance. If your cancellation is within 24 hours of your appointment, you may be charged a $25.00 missed appointment/late cancellation fee. If you continue to miss appointments, you may be dismissed from the practice.

Surgical Procedures

If you are scheduled for any surgical procedures, please note, we require at least 72 hours notice to either cancel or reschedule your procedure. A notice of less than 72 hours will result in a $100.00 late cancellation fee.

Consent to Photograph

This form is to be used only for photographs taken for treatment for Pure Dermatology & Cosmetic Center's own healthcare operations, as allowed under the Federal Privacy Laws. The term "photograph" as used herein includes video or still photography, digital, any other format, and any other means of recording or reproducing images.

The undersigned hereby consent and authorize for photographs or other images of self and/or body for purposes of identification, diagnosis, treatment, payment, and healthcare operations of Pure Dermatology & Cosmetic Center, while receiving treatment at the office. Photographs or other images taken will become part of my medical record. This consent is with the understanding that the images from such photography are used for the patient's treatment.

I have read, understand, and agree to the above No Show/Appointment Cancellation Policy and Consent to Photograph.

____

Patient/Guardian (if patient is a minor) Signature **Date**

____

Patient Printed Name **Date of Birth**

Pure Dermatology & Cosmetic Center
500 Superior Ave Suite 335, Newport Beach, CA 92663
Phone: (949) 706-1469 Fax: (949) 706-7307
www.PureDermOC.com info@PureDermOC.com

Consent for Photography/Authorization for Use and Disclosure

This form is to be used only for photographs taken for treatment for Pure Dermatology & Cosmetic Center's own healthcare operations, as allowed under the Federal Privacy Laws. The term "photograph" as used herein includes video or still photography, digital, any other format, and any other means of recording or reproducing images.

I hereby authorize the use or disclosure of photography for other purposes including research publication, outside education, marketing, and public relation (i.e. Pure Dermatology & Cosmetic Center publications, websites, printed materials, social media websites, etc.) If the photograph will be used for office marketing purposes, all measures will be taken to make the images **non-identifiable**. Pure Dermatology & Cosmetic Center will not sure such photographs or images for any other purposes without my specific written consent. I and my successors or assigns hereby hold Pure Dermatology & Cosmetic Center, its employees or physician(s), and any other person(s) participating in my care harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge and agree to the terms and conditions of this document:

____

Patient/Guardian (if patient is a minor) Signature **Date**

____

Patient Printed Name **Date of Birth**

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