comprehensive dermatology
OF LONG BEACH

REGISTRATION/CONSENT FORM

(PLEASE PRINT)

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle:			☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep /
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F
Home phone :	Cell Phone:		**IF WE NEED TO CONTACT YOU**: OK to leave detailed voicemail ☐ Leave call back # only ☐	
Street address/ P.O. Box:	City:		State:	ZIP Code:
Occupation:	Employer:			
Email Address:	Consent to communicate via Email ☐ Yes ☐ No			
Person(s) we are authorized to release medical results to (if any):				
How were you referred to our office? ☐ Current Patient _____ ☐ Internet/Yelp ☐ Physician _____				
Primary Care Physician:	Phone No. ( )			
Referring Physician:	Phone No. ( )			
Spouse's or Parent's Last Name: First:				
Spouse's or Parent's Phone No. ( )	Birth date: / /			

INSURANCE INFORMATION

Please give your insurance card and photo ID to the receptionist. You must notify us if this is an accident or work related visit.

Subscriber's name:	Subscriber's Birth date: / /
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Cell phone no.: ( )	Additional phone no.: ( )

Don't forget to fill out the reverse side

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION:
All professional services rendered are charged to the patient; necessary forms will be completed to expedite insurance carrier payments the patient is responsible for all fees regardless of insurance coverage. All services provided to you as a patient of Comprehensive Dermatology of Long Beach, PC are payable at the time of service and are the sole responsibility of you "the patient" and/or guarantor of "your children". I hereby authorize Comprehensive Dermatology of Long Beach, PC to furnish insurance companies or their representative's information concerning my/my dependents illness and treatments and I hereby assign to Comprehensive Dermatology of Long Beach, PC all payments for medical services rendered by myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I hereby authorize and release the doctor and whomever he/she may designate as his/her assistant to administer treatment, physical exam, x-ray studios, laboratory procedures, medical care or any clinical service that he/she deems necessary in my case, and I further authorize him/her to disclose all or part of my (patients) record to any person or corporation which is or may be liable under contract to the clinic or to the patient or to a family member or employer of the patient for all or part of the clinic charge, including but not limited to hospital or medical services company, insurance company, workers compensation carries, welfare funds, or the patients employer.

PATIENT INFORMATION CONSENT:
I understand that Comprehensive Dermatology of Long Beach, PC may need to use and disclose information about my health or medical problems for the purpose of arranging, conducting, or referring my treatment; for obtaining payment for services and for the purpose of operating the practice. I consent to the use of my information for the purpose of treatment, payment, and health care operations.

I understand that my consent is not needed if the law requires Comprehensive Dermatology of Long Beach, PC to report some aspect of my protected health information to a government agency (for example suspected abuse, communicable disease, and potential bodily harm to myself or others).

I understand that I have the right to review Comprehensive Dermatology of Long Beach, PC privacy notice, to request restrictions be put on the use of my information, and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purpose of treatment, payment or operations, Comprehensive Dermatology of Long Beach, PC may refuse to undertake my care.

I, the undersigned, hereby consent to the following treatment: administration an performance of all treatments administration of any needed anesthetics, performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, use of prescribed medication, performance of diagnostic procedures/tests, cultures, biopsies, and surgery, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees. I fully understand that this is given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that Comprehensive Dermatology of Long Beach, PC may include consent at satellite offices under common ownership.

MEDICARE PATIENTS:
I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Comprehensive Dermatology of Long Beach, PC.

HIPAA ACKNOWLEDGEMENT:
I have received and have read Comprehensive Dermatology of Long Beach, PC Notices of Privacy Practices.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its content. Also that all information provided above is true and correct to my knowledge.

_____ _____

Patient/Guardian Signature Date

Name: _____ DOB: _____ DATE: _____

PATIENT HEALTH QUESTIONNAIRE

All information in this questionnaire is strictly confidential and will become part of your medical record.

PATIENT MEDICAL HISTORY

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Arterial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension (High Blood Pressure)
- ☐ HIV/AIDs
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____

PAST SURGICAL HISTORY

Date	Surgery

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Other _____

HISTORY OF SKIN CANCER

- ☐ Basal Cell Location _____ Year _____
- ☐ Squamous Cell Location _____ Year _____
- ☐ Melanoma Location _____ Year _____
- ☐ Other Location _____ Year _____
- ☐ Unknown

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

Do you have a family history of melanoma? ☐ Yes ☐ No If yes, who? _____

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

Don't forget to fill out the reverse side

Name: _____ DOB: _____ DATE: _____

PHARMACY

Name: _____ Phone Number: (_____)_____

Address: _____

MEDICATIONS (PRESCRIPTIONS, OVER-THE-COUNTER, AND HERBAL)

Prescription	Dosage

ALLERGIES

_____

_____

SOCIAL HISTORY

Cigarette Smoking

- ☐ Never Smoked
- ☐ Quit (Former smoker)
- ☐ Current, some day smoker
- ☐ Current, every day smoker

Alcohol Use

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

REVIEW OF SYMPTOMS

Do you have any of the following?

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Fever or Chills
- ☐ Unintentional Weight Loss
- ☐ Night Sweats
- ☐ Joint Aches
- ☐ Headaches

ALERTS

Do you have any of the following?

- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Artificial Joints (within past 2 years)
- ☐ Artificial Heart Valves
- ☐ Premedication (prior to procedures)
- ☐ Blood Thinners
- ☐ Pregnancy/Planning a Pregnancy
- ☐ Breastfeeding
- ☐ Bleeding Disorder
- ☐ Allergy to Adhesive
- ☐ Allergy to Latex
- ☐ Allergy to Topical Ointment
- ☐ Allergy to Lidocaine
- ☐ Rapid Heartbeat with Epinephrine
- ☐ Problems with Scarring/Keloids

PRIMARY CARE PHYSICIAN (PCP): _____

HOW WERE YOU REFERRED TO OUR OFFICE?

- ☐ Patient: _____
- ☐ Internet
- ☐ Doctor: _____

EMPLOYMENT

Employer: _____ Occupation: _____

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PATIENT FINANCIAL POLICY

In order to help you navigate the ever more complex healthcare system, we are providing this letter to explain our billing policies and how your insurance provider processes claims. If you have any questions regarding the content of this letter, please let us know. We would be happy to discuss it with you. We remain dedicated to providing the best care to our patients. Your understanding of this system will make it easier for you to be engaged in the use of your healthcare resources.

UNDERSTANDING YOUR HEALTH INSURANCE

Your health insurance policy is a contract between you and the insurance company. It is an agreement that your insurance will pay for covered medical services as long as your premiums are paid. They may not pay for every bill or treatment. It is very important that you know which medical treatments they will pay for and which expense they will not cover. Please keep in mind that determination of benefits is NOT a guarantee of payment.

DEDUCTIBLE

The deductible refers to the amount of money that you would need to pay before any benefits from the health insurance policy can be used. This is usually a yearly amount so when the policy is renewed, usually after a year, the deductible would be in effect again. Some services may be available without meeting the deductible first. Usually there are separate individual deductible amounts and total family deductible amounts.

CO-INSURANCE

The insurance company has a set fee limit for each type of treatment. The insurance company will pay the maximum according to your plan policy and anything beyond that is your responsibility. This is usually a percentage amount that is your responsibility. A common co-insurance split is 80/20. This means that the insurance company will pay 80% of the procedure and you are required to pay the other 20%.

CO-PAYMENTS

The co-payment is a fixed amount that you are required to pay at the time of service. It is usually required for basic doctor visits and when purchasing prescription medications.

OUT-OF-POCKET

This is the cost one would pay out of their own pocket. An out of pocket expense may refer to the co-payment, coinsurance, or deductible is. Also, when the term annual out-of-pocket maximum is used, that is referring to how much the insured would have to pay for the whole year out of their pocket, excluding premiums.

EXCLUSIONS/NON COVERED BENEFIT/EXPERIMENTAL TREATMENTS OR DRUGS/NON-PRESCRIPTION DRUGS

These exclusions are the things that the insurance policy will not cover.

MEDICARE FINANCIAL POLICY

Medicare requires that you pay an annual deductible per calendar year. We collect any outstanding deductible due on the day that services are rendered unless your secondary/supplemental carrier pays the Medicare Part B deductible. Please make every effort to know your secondary/supplemental insurance coverage. We will ask you about this during your visit to remind you.

After the deductible is satisfied, Medicare will pay 80% of allowed charges. If you do not have secondary/supplemental coverage, you will be responsible for 20% of those charges on the day the services are rendered.

Medicare does not pay for all outpatient medical costs. By law, we cannot "write off" the difference, therefore, you are responsible to pay us if there is a balance.

SELF-PAY FINANCIAL POLICY

In the event that your insurance company is not contracted with us but you still wish to be seen by our physicians, the following list will help explain your responsibilities. We require that these visit fees be paid at the time care is rendered.

- Initial/1st office visits (for a given condition)$200
- Follow up visits (for a previously evaluated condition) $125
- Full body skin exams (after the initial visit) $200
- Biopsies $100-$250 per lesion (exclusive of pathology costs)
- Please ask your physician about costs of procedures not listed here

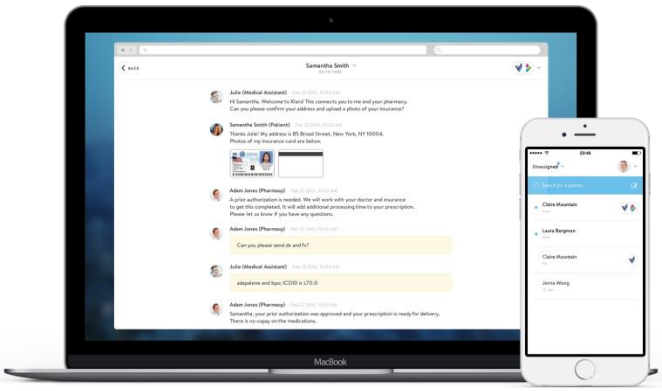
LAB/X-RAY/DIAGOSTIC SERVICES

Your care often requires the use of laboratory studies, imaging studies, or pathology evaluation. These studies are not performed at our practice. If your care does require the use of any of these modalities, you will receive a separate bill from the physician or laboratory providing that specific service. Please understand that we cannot control these costs. If you have any questions regarding these costs, please ask your physician prior to your procedure.

OUR HOPE

We want to provide you with the best care possible. In the current economic climate, your resources are especially valuable. It is our experience that informed patients are better able to allocate their resources in a way that is comfortable for them. Hopefully, this letter will help you to achieve the goal of being better informed.

K L A R A



Tired of Playing Phone Tag?

Chat with us on Klara. Secure and easy communication.

What is Klara?

- Klara is a communication channel. Klara is not a replacement for in-person medical consultations or appointments. Use of Klara should replace cases where phone or email would be used to communicate.
- Klara is an app that you can access via your web browser (Google Chrome, Safari, Internet Explorer, etc) or iOS app found in the Apple Store.
- You can then use your Klara account to reach our staff, doctors, and even your pharmacy.
- Klara use and access is free for all patients.
- Your information is secure, private, and the app is 100% compliant with HIPAA-standards.

Accessing Your Klara Account

- Klara invitations are sent via email and text message.
- You must click the link and set up your password.
- You will receive a notification every time you have a new message waiting for you in Klara.
- You can also access your account by going directly to https://patient.klara.com.
- Klara provides “read receipts” so you can see when your message was read by staff.

When To Use Klara

- Have test results sent to your phone, laptop, or tablet.
- Ask follow up questions after appointments, such as prescription dosage questions.
- Send prescription refills and all other follow-up questions via Klara.
- Ask a question that you may have been uncomfortable bringing up at the time of your visit.
- Send a picture of your insurance card before your appointment or to update your current insurance on file.
- Easily coordinate your appointment without playing phone tag.
- *If you have a serious issue, please call 911 directly.*

When NOT To Use Klara

- To cancel same day appointments.
- If you are running late.

Additional Klara Account Set-up

- If you cannot find your original activation message, please visit https://patient.klara.com and click “Don’t Know Your Password?”
- Your activation email will be sent over ASAP, please use the link in the email to set a password for your account.
- From there, you can access your messages.

*For additional information, please send an email to support@klara.com for any issues or questions that arise regarding your Klara account. If you have an emergency, please dial 911 directly. Klara is not a telemedicine service or a replacement for in-person medical care.