Orange County SkinLab Dermatology & Dermatopathology

Patient Information Sheet

Patient's Last Name: _____ **First:** _____

Middle: _____ **Preferred Name:** _____

Date of Birth: _____ **Age:** _____ **Gender:**: _____ **Pronouns**: _____

HOME Address: _____ _____
Street Apt/Unit #

_____ _____ _____
City State ZIP Code

Telephone: _____ _____ _____
CELL (XXX)-XXX-XXXX HOME (XXX)-XXX-XXXX WORK (XXX)-XXX-XXXX

Email: _____ **Marital Status:** Single Married Widowed Divorced Partnered

Preferred Pharmacy: _____ _____
Name Phone Number (XXX)-XXX-XXXX

_____
Address

Insurance Carrier: _____ **Subscriber's Name:** _____ **Subscriber DOB:** _____
(If not patient) (If not patient)

Emergency Contact: _____ _____ _____
(Other than accompanying parent if minor) First and Last Name Relationship to Patient Phone Number (XXX)-XXX-XXXX

Primary Care Physician: _____ _____ _____
First Name Last Name Phone Number (XXX)-XXX-XXXX

How did you hear about our office?

OC SkinLab Website Online Review Site Google Search Social Media Magazine

Referral/Word of Mouth Insurance Carrier Other: _____

Signature: _____ **Date:** _____

Patient Medical History Form

Patient's Name: _____ **DOB:** _____

Are you in good general health now? **Y N** Current weight: _____ Height: _____

Have you ever had any of the following?

Asthma	**Y N**	Diabetes	**Y N**
Seasonal Allergies	**Y N**	Internal Cancer	**Y N**
Hives	**Y N**	High Blood Pressure	**Y N**
Sinus Problems/Migraines	**Y N**	Heart Trouble	**Y N**
Eczema	**Y N**	Thyroid disease	**Y N**
Boils	**Y N**	Jaundice/Hepatitis	**Y N**
Keloid/ thickened scars	**Y N**	Kidney Disease	**Y N**
Allergy to local anesthetics	**Y N**	Glaucoma	**Y N**
Bleeding ulcer	**Y N**	Epilepsy	**Y N**
HIV/AIDS infection	**Y N**	Tuberculosis	**Y N**
Smoke or vape?	**Y Past Never**	Organ Transplant	**Y N**
Joint Replacement	**Y N**	Are you currently taking blood thinners?	**Y N**

What disease(s), if any, runs in your family? Please specify.

_____

_____

What, if any, skin cancer have you had previously? Please include dates.

_____

_____

What medications or foods are you allergic to and what is the reaction?

_____

_____

Describe any previous skin problems.

_____

_____

_____

Do you have a past or current history of psychiatric illness, eating disorder, depression, or anxiety? Please specify.

_____

Have you had any hospitalizations or surgeries? Please specify and include dates.

_____

_____

Women Only, please answer the following:

Are you pregnant? **Y N** If yes, your expected delivery date: _____

Do you take birth control pills? **Y N** *Please include brand and dosage on the medication list (next page).*

Are you breastfeeding? **Y N**

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Medication List

List all prescription and non-prescription medications including all over-the-counter (OTC), herbals and vitamin/mineral/dietary supplements that you are currently taking.

Patient's Name: _____ **DOB:** _____

Medication Name	Dosage	Frequency	Route of Administration (ex. oral, topical, inhaled, etc.)

CONFIDENTIAL CHANNEL OF COMMUNICATION REQUEST

Patient's Name: _____ **DOB:** _____

As required by HIPAA of 1996 you have the right to request that communication concerning your personal health information be made through confidential channels. Orange County SkinLab will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided in order to contact you with results from laboratory tests, biopsies, treatment recommendations and payments.

I, _____(print full name) hereby request the use of the following communication channels for information related to my personal health, treatment or payment for treatment. This request supersedes any prior request for confidential communications I have made.

Please check box if you wish to allow us to contact you via email: ⬜

Preferred email address: _____

Preferred Phone Contact: _____
(XXX)-XXX-XXXX

Alternate Phone Contact: _____
(XXX)-XXX-XXXX

⬜ DO NOT leave messages on my voicemail

⬜ OKAY TO leave messages on my voicemail

If you are unavailable, Orange County SkinLab has permission to speak with _____.

If not signed by the patient, please indicate relationship:

⬜ Parent or guardian of minor patient

⬜ Beneficiary or personal representative of deceased patient

⬜ Guardian or conservator of an incompetent patient

Signature: _____ **Date:** _____

Patient Acknowledgement and Authorizations and Patient Assignment of Benefits

All Patients, Please Read and Sign:

Patient Acknowledgement and Authorizations

This form is required to allow us to evaluate and treat you, and to bill and communicate with your insurance company.

I authorize Orange County SkinLab to conduct examinations, and perform procedures as are medically required to administer treatment and medications as deemed necessary or advisable.

Orange County SkinLab is hereby authorized to release a complete report of services rendered, diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billing agents, insurance carriers, employer's workers' compensation insurance company, other third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other Intermediaries responsible for payment of services rendered. The release of information consent may be revoked at any time by giving written notice.

If release of information is refused, the patient will be held responsible for payment of all charges for services rendered.

In consideration of medical goods and services provided by Orange County SkinLab, I give all rights, title and interest to the medical/surgical/supply reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefits including Medicare Part B. I remain fully responsible for payment of any and all charges not covered by insurance.

Patient Assignment of Benefits

This form is required to allow us to bill and accept direct payment from your insurance company or other payer.

Orange County SkinLab will bill all primary and secondary insurances, but I am ultimately responsible for payment for the services and any supplies/equipment I receive.

I hereby assign to Orange County SkinLab any insurance or other third party benefits available for healthcare services provided to me. I understand that Orange County SkinLab has the right to refuse or accept assignment of such benefits.

If these benefits are not assigned to Orange County SkinLab, I agree to forward to Orange County SkinLab all health insurance and other third party payments that I receive for services rendered to me immediately upon request.

I understand that my signature requests that payment be made directly to Orange County SkinLab. I authorize release of medical information necessary to pay the claim.

A photocopy of this assignment is to be considered as the original.

I have read and agree with the above Patient Acknowledgement and authorizations and Patient Assignment of Benefits. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient or Responsible Party's Signature: _____ Date Signed:_____

Patient's Printed Name: _____ Patient's Age:* _____

***NOTICE: If patient is a minor (under 18 years of age) the parent of responsible party must complete and sign the Consent for Treating of Minor Form.**

Acknowledgement of Receipt Patient Financial Policy and Notice of Privacy Practices

All Patients, Please Read and Sign:

Patient Financial Policy

Thank you for your time in understanding the financial policy of the Orange County SkinLab. It is our desire to serve your medical needs as well as we possibly can. By understanding the financial policy we utilize, we can make billing a non-issue and concentrate on providing you with the best possible care and treatment.

All patient information is confidential and subject to state laws including Confidentiality of Medical Insurance Act Section 56 of the California Civil Code and the Health Insurance Portability and Accountability Act (HIPAA) P.L.104-191.

I have read and agree with the Patient Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient or Responsible Party's Signature: _____ Date Signed:_____

Patient's Printed Name: _____ Patient's Age:* _____

***NOTICE: If patient is a minor (under 18 years of age) the parent of responsible party must complete and sign the Consent for Treating of Minor Form.**

Notice of Privacy Practices

I hereby acknowledge that I was offered and/or received a copy of Orange County SkinLab's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Any questions regarding the Privacy Practices of the Orange County SkinLab should be directed to Dr. Hure at info@ocskinlab.com.

I would like to receive a copy of any amended Notice of Privacy practices (circle one) Yes No

I prefer to receive a copy via (circle one): Email Handout Mail Fax

Print Name: _____

Signature: _____

Date: _____

If not signed by the patient, please indicate relationship:

⬜ Parent or Guardian of Minor Patient

⬜ Guardian or Conservator of an incompetent patient

For Staff Use:	
Sent/Given Copy	By _____ Date _____

Credit Card Authorization Form

Please complete all fields. You may cancel or amend this authorization at any time by contacting us. This authorization will remain in effect until cancelled in writing.

Credit Card Information	
Card Type: ⬜ MasterCard ⬜ VISA ⬜ Discover ⬜ AmericanExpress ⬜ Other: _____	
Cardholder Name (as shown on card):	
Card Number:	
Expiration Date (MM/YY):	CVV:
Billing Address ZIP Code:	

I, _____, authorize Orange County SkinLab to charge my credit card above for agreed upon purchases, including but not limited to co-payments, co-insurance, deductibles, patient balances, and no-show fees. I understand that my information will be saved to file for future transactions on my account.

Customer Signature: _____ **Date:** _____

Patient Financial Policy

This form describes the Financial Policy of Orange County SkinLab, which governs how we handle the financial aspects of the care, treatment, supplies and other services you receive here.

Thank you for choosing Orange County SkinLab, as a healthcare provider. We are committed to your treatment being a successful experience. Our Medical and office staff will work very hard to make sure that your paperwork is filed accurately and promptly. Because most of the data we have comes from you, please help us maintain accurate records by letting us know whenever important data changes (your address, telephone number, any changes to your name, your medical insurance, etc.) when paying for services, supplies, etc. We are able to accept all major credit cards, checks and cash.

Insurance and Insurance Collection
We will attempt to bill whichever insurance you have advised us of as a courtesy. Please understand that insurance reimbursement can be a long and difficult process for medical providers AND patients. There are instances when insurers will stall, deny, pend, spend weeks and months reviewing claims, and then reduce or deny any reimbursement officered. Our billing company has undergone extensive training to maximize your insurance reimbursement while reducing the time in which they pay.

Non-Contracted indemnity insurance plans/No insurance card
If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay for services in advance. If we are able to collect from your insurance company after you have fully paid your account, we will issue you a refund. We will attempt to bill your insurance company using the information you have supplied to us as a courtesy. Our office, as a convenience and a service to you, will absorb all costs incurred for this billing. Please note that not all insurers agree to contract with us.
In the event that your insurance does not reimburse us within ninety (90) days, we will transfer this balance to you as your responsibility and send you a statement. We are NOT Medi-Cal providers, and do not accept Medi-Cal. We do not accept any other State's Medicaid programs. At the current time, we are not within network for Covered California or Affordable Care Act coverage.

Know Your Plan Benefits – Non Covered Services are Your Responsibility
Each and every insurance company and plan, including Medicare, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have relative to your own benefits with them. Co-payments are due at the time of service. You should ask your insurer what the amount is and have it ready at the time of your visit. We may decline to see patients for non-emergent visits if co-payments are not made at the time of the visit. Orange County SkinLab may provide services that may not be covered as a benefit of your specific plan with your insurer. Patients or Guarantors are financially responsible for any and all services provided that may not be covered by your insurance plan.
It is your responsibility to know and understand your specific insurance plan and what benefits are provided. Some procedures you may undergo will involve removing tissue. The charges for this process are known as Laboratory/Pathology charges and will appear on your bill if performed. The physician who looks at the slide and provides her opinion based on those slides is known as the Dermatopathologist (Dr. Hure). There is a charge for her professional opinion, which is independent of the charge for preparing the actual slide or taking the biopsy.

PPO Plans
As a contracted provider, Orange County SkinLab has agreed to accept a discounted rate from your plan for covered services, however all co-payments, co-insurance and/or deductibles are your responsibility and will be collected on the day of service.

Medicare
As a participating provider, we will bill your Medicare carrier. You are responsible for your annual deductible and 20% of the co-insurance portion. We must collect this. We will be happy to bill any secondary (or Tertiary) insurance you may have once we have been informed that you have such coverage in effect. If any balance remains once Medicare and these insurers have processed our claims, we will transfer responsibility for payment to you, and send you a statement.

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Important reminder for Medicare enrollees: If you qualified for Medicare coverage and decided to enroll in a managed Medicare+Choice/Medicare Advantage plan (e.g. MemorialCare, Blue Cross Senior Secure, SCAN) you are not eligible to be seen at Orange County SkinLab unless you choose to be a cash patient..

Secondary Insurers
Having more than one insurance does NOT necessarily mean that your services are covered 100%. Depending on your plan's benefits, the secondary insurers will pay as a function of what your primary insurer pays. We will bill your secondary insurer as a courtesy. You are responsible for any balances after your insurers have processed our claims.

Divorce Decrees
Orange County SkinLab is NOT a party to any divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult.

Minor Patients
The adult accompanying a minor and the parents (guardians) of the minor are responsible for full payment for services rendered to the minor patient. For unaccompanied minors, non-emergent or treatments unrelated to an ongoing care plan, will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at the time of service has been obtained or verified.

Return Check Fees
There is a $25.00 banking fee for all returned checks. This sum is used to offset the fees incurred by OC SkinLab from our financial institution. If your check is returned from the bank, we may NOT ACCEPT an additional check as payment on your account. Future payments must be made with cash, money order or credit card.

Collections/Pre-Collections
Orange County SkinLab will send you a statement after your insurers have been billed and your insurers have considered your charges. We will charge interest of 1.5% (18% annually) on all outstanding balances after 30 days. If no payment is received after 120 days, your account may be turned over to a collections agency and a $25.00 late payment/pre-collection fee will be added to your account to offset the administrative costs incurred when accounts are assigned for collection.

Forms
Completion of all forms will require a Telemedicine visit and incur the appropriate visit fee.

Records and Copying
(First complete and sign a Release of Records from authorizing us to release your records. We cannot begin the process without this documentation.) There is no charge for electronic faxing of records. If paper copies are requested, a charge for copying medical records will be incurred. There is a fee of .25 cents per page printed, plus, reasonable clerical fees of $24.00/hour (charged in quarter hour increments), which includes the time spent in locating the records plus postage fees. The records will not be sent until the fee is paid. These fees are set by the State of California (Health & Safety Code section 123110), not Orange County SkinLab.

No-Shows and Cancellations
Patients who fail to show ("no-show") at their initial office or telemedicine visits without appropriate notice will not be allowed to rebook for future appointments. Patients who cancel within 24 hours of the scheduled appointment will not be allowed to rebook after the third occurrence. All patients who fail to show or cancel within 24 hours of their appointment time will be subject to a "no-show" fee of $75.