South Coast Dermatology Institute

We need the information below, which remains strictly confidential. **PLEASE PRINT CLEARLY**

PATIENT NAME: _____ DATE: _____
LAST FIRST M/I

GENDER: M / F DOB: _____/ _____ / _____ AGE: _____ MARITAL STATUS: _____

ADDRESS: _____

HOME #: _____ WORK #: _____ MOBILE #: _____

PREFERRED #: HOME/ WORK/ MOBILE EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

Has a family member ever been a patient? If yes, name and relationship: _____

HOW DID YOU HEAR ABOUT SCDI? _____ REFERRING DR: _____

INSURANCE SUBSCRIBER INFORMATION: (*IF NOT SELF, PLEASE PROVIDE RESPONSIBLE PARTY INFORMATION*)

INS CARRIER: _____ SUBSCRIBER ID #:_____ GROUP#: _____

NAME: _____ DOB:_____ RELATIONSHIP TO PT: _____

ADDRESS: _____

SUBSCRIBER'S CONTACT #: _____ EMAIL: _____

PREFERRED PHARMACY: _____ CONTACT #:_____

ADDRESS: _____
STREET CITY ZIP CODE

MEDICAL HISTORY INTAKE

PAST MEDICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ANXIETY	DEPRESSION	HYPOTHYROIDISM
ARTHRITIS	DIABETES	LEUKEMIA
ARTIFICIAL JOINTS	END STAGE RENAL DISEASE	LUNG CANCER
ASTHMA	GERD	LYMPHOMA
ATRIAL FIBRILLATION	HEARING LOSS	PACEMAKER
BPH	HEPATITIS	PROSTATE CANCER
BONE MARROW TRANSPLANTATION	HYPERTENSION	RADIATION TREATMENT
COLON CANCER	HIV/AIDS	SEIZURES
COPD	HYPERCHOLESTEROLEMIA	STROKE
CORONARY ARTERY DISEASE	HYPERTHYROIDISM	VALVE REPLACEMENT

OTHER_____

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

APPENDIX REMOVED	KIDNEY BIOPSY
BLADDER REMOVED	KIDNEY REMOVED (RIGHT, LEFT)
MASTECTOMY (RIGHT, LEFT, BILATERAL)	KIDNEY STONE REMOVAL

South Coast Dermatology Institute

We need the information below, which remains strictly confidential. **PLEASE PRINT CLEARLY**

(Continued):

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
PTCA
MECHANICAL VALVE REPLACEMENT
SPLEEN REMOVED
HYSTERECTOMY: FIBROIDS
HYSTERECTOMY: UTERINE CANCER
JOINT REPLACEMENT, KNEE (RIGHT, LEFT, BILATERAL)
JOINT REPLACEMENT, HIP (RIGHT, LEFT, BILATERAL)
KIDNEY TRANSPLANT
OVARIES REMOVED: ENDOMETRIOSIS
OVARIES REMOVED: CYST
OVARIES REMOVED: OVARIAN CANCER
PROSTATE BIOPSY
TURP
SKIN BIOPSY
BASAL CELL CANCER
SQUAMOUS CELL CARCINOMA
MELANOMA
BIOLOGICAL VALVE REPLACEMENT
HEART TRANSPLANT
TESTICLES REMOVED (RIGHT, LEFT, BILATERAL)
JOINT REPLACEMENT
OTHER _____

SKIN DISEASE HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ACNE	FLAKING/ITCHING SCALP	ASTHMA
BLISTERING SUNBURNS	DRY SKIN	COLD SORES
ACTINIC KERATOSES	MELANOMA	BASAL CELL CANCER
SQUAMOUS CELL CANCER	PRECANCEROUS MOLES	ECZEMA
HAYFEVER/ ALLERGIES	POISON IVY	PSORIASIS OTHER_____

DO YOU WEAR SUNSCREEN? YES NO
IF YES, WHAT SPF? _____

FAMILY HISTORY OF MELANOMA? YES NO
IF YES, WHICH RELATIVE(S): _____

DO YOU TAN IN A TANNING SALON? YES NO

ANY OTHER FAMILY HISTORY: _____

SOCIAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ALCOHOL USE:	CIGARETTE SMOKING:	PREGNANCY:
ALCOHOL: NONE	NEVER SMOKED	NEVER PREGNANT
ALCOHOL: SOCIALLY	FORMER SMOKER	PLANNING PREGNANCY
ALCOHOL: 1-2/ DAY	SMOKES SOCIALLY	PREVIOUS PREGNANCY
ALCOHOL: 3+/ DAY	SMOKES DAILY	CURRENTLY PREGNANT
	VAPOR USER	BREASTFEEDING

MEDICATION: (PLEASE WRITE ALL CURRENT MEDICATIONS):_____

_____

_____

ALLERGIES: _____

PATIENT SIGNATURE RESPONSIBLE PARTY/INSURED RELATIONSHIP DATE

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY/ALL OF THE MONIES NOT PAID BY MY INSURANCE INCLUDING COPAYS.I WILL NOTIFY THIS OFFICE OF ANY CHANGES IN THE ABOVE INFORMATION. I HEREBY AUTHORIZE SOUTH COAST DERMATOLOGY INSTITUTE TO FURNISH TO MY INSURANCE, INFORMATION CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO SOUTH COAST DERMATOLOGY INSTITUTE ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO ME AND/OR MY DEPENDENTS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS. I ACKNOWLEDGE THAT I HAVE REVIEWED THE NOTICE OF PRIVACY POLICIES.

South Coast Dermatology Institute

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ DOB:_____

Patient Address: _____ City: _____ State: _____ Zip: _____

PROVIDED BY: SCDI / VINCE AFSAHI M.D., SELISE JAMES PA-C, & ASSOCIATES

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against international or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases a lack of access to complete medical records may results in adverse drug interactions or allergic reaction or other judgment error;

Please initial after reading this page: _____

INFORMED CONSENT FOR TELEMEDICINE

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. *Vince Afsahi M.D., Selise James PA-C, & Associates* (*name of Physician*) has explained the alternative to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform *Vince Afsahi M.D., Selise James PA-C, & Associates* (*name of Physician*) of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of California and will be present in the state of California during all telehealth encounters with *Vince Afsahi M.D., Selise James PA-C, & Associates* (*name of Physician*).

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize *Vince Afsahi M.D., Selise James PA-C, & Associates* (*name of Physician*) to use telemedicine in the course of my diagnosis and treatment.

_____ _____

Patient's Signature (or authorized person to sign for patient) **Date**

_____

If authorized signer, relationship to patient

_____ _____

Witness **Date**

_____ _____

Physician's Signature **Date**

I have been offered a copy of this consent form. _____ (Patient's initials)

South Coast Dermatology Institute

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name - Patient or Representative

_____

Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____

Printed Name - Practice Representative

_____

Signature Date

South Coast Dermatology Institute

FINANCIAL POLICIES

Please read and sign below: South Coast Dermatology Institute (SCDI) recognizes the need for an understanding between patient and doctor regarding financial arrangements for medical care. The benefits that I may receive from my insurance company are a settlement matter solely between myself and the insurance carrier. I agree that payment responsibility for copays, meeting deductibles, payment shortfalls or percentages is my direct obligation and are due and payable at the time of service. Please note that the patient is responsible for any and all charges not paid for by the insurance company.

INSURANCE PLANS: COVERAGE AND ELIGIBILITY

SCDI is a provider on many PPO insurance plans. We do not accept any HMO or any Medicare HMO plans, including Greater Newport Physicians and Monarch. Some of the services offered by SCDI may not be covered by insurance companies because they are considered "not reasonable and necessary" or they are cosmetic in nature. This is determined entirely by the insurance company. If I receive services that are not covered by my insurance company because they are considered "not reasonable and necessary", I agree to pay those charges in full.

If it is determined after submission of my forms to my insurance company that I am ineligible for coverage I do agree to pay those charges in full.

If SCDI is not on my PPO plan and I elect to be seen at his office, or I do not have insurance, I agree to pay in full for all services at the time of the visit.

COSMETIC PROCEDURE PAYMENT AND CANCELLATION POLICY

Cosmetic procedures are not covered by insurance. We offer cosmetic consultation with our aesthetically trained Patient Coordinator or Medical Esthetician for a nominal fee. There is a $75 fee for cosmetic consultations with a physician. All cosmetic consultation fees can be applied to products or procedures purchased within 30 days of the consultation.

All cosmetic procedures are non-refundable and payments are due at the time of service or prior.

APPOINTMENT CANCELLATION POLICY

A $25 no-show fee will be charged to your account if you fail to cancel or reschedule your appointment at least 24 hours in advance.

PRODUCT RETURNS

Any product purchased may be returned or exchanged within 7 days of purchase. A 20% restocking fee will apply to all product returns

OTHER CHARGES

A fee will be charged for any returned checks.

I understand that if blood work or biopsies are done, that I may receive a separate invoice from the laboratory or the pathology doctor who reviews and interprets my biopsy specimens at a later date. I will be responsible for paying all such invoices directly to that laboratory or physician.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign SCDI all money to which I am entitled to for medical and/or surgical expense relative to the services rendered, but not to exceed my indebtedness to SCDI. It is understood that any money received from my insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to SCDI for charges not covered by this assignment. I further agree that in the event of non-payment, to bear the cost of collection, and/or court costs and reasonable legal fees should this be required.

Patient Name: _____ **Signature:** _____ **Date:** _____

South Coast Dermatology Institute

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____. (name of patient or guardian)

"Physician" shall be understood to mean SOUTH COAST DERMATOLOGY INSTITUTE, Vince Afsahi. M.D. and associates

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursue, I (the patient) and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness(es) in the same specialty as Physician. FUrthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Academy of Dermatology

In further consideration for this, Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

_____

Patient / Guardian

_____

Date of Signature

Physician's Copy

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contractual agreement 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 contractual agreement, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress, or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete resolution of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www.cmanet.org. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below.

Earlier effective date: _____ Patient's Initials: _____

ARTICLE 7: I have read and understand all of the information in the pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACTUAL AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS AGREEMENT.

_____ Dated: _____ , _____

(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE

I agree to be bound by the terms set forth in the Agreement and in the Rules specified in Article 5 above.

_____ Dated: _____ , _____

(Physician or Duly-Authorized Representative)

_ _ _ _ _ _ SCDI / VINCE AFSAHI M.D. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Title -- e.g., Partner, President, etc. Print name of Physician, Medical Group, Partnership or Association