South Coast Dermatology Institute

PATIENT NAME:_____DATE:_____
LAST FIRST M/I

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

ADDRESS:_____CITY:_____ZIP:_____

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

PREFERRED #: HOME/ WORK/ MOBILE EMAIL:_____

SOCIAL SECURITY #:_____-_____-_____ EMPLOYER:_____ OCCUPATION:_____

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

HOW DID YOU HEAR ABOUT SCDI? _____REFERRING DR:_____

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

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

NAME: _____ DOB:_____ RELATIONSHIP TO PT: _____

ADDRESS: _____

SUBSCRIBER'S CONTACT #: _____ EMAIL: _____

SECONDARY INSURANCE 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)

ARTHRITIS
CEREBROVASCULAR ACCIDENT (STROKE)
COPD
DEPRESSION
DIABETES
END STAGE KIDNEY DISEASE
EPILEPSY
HYPERTENSION
LIVER DISEASE
HIV/AIDS
HYPERCHOLESTEROLEMIA
LEUKEMIA
MALIGNANT LYMPHOMA
MALIGNANT TUMOR OF COLON
RADIATION THERAPY
TRANSPLANT
TRANSPLANT OF BONE MARROW
OTHER_____

South Coast Dermatology Institute

PAST SURGICAL HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

EXCISION OF BASAL CELL CANCER
EXCISION OF MELANOMA
EXCISION OF SQUAMOUS CELL CANCER
HISTORY OF COLECTOMY
HISTORY OF COSMETIC SURGERY
SURGICAL BIOPSY OF SKIN

SKIN DISEASE HISTORY: (PLEASE CIRCLE ALL THAT APPLY)

ACNE
ACTINIC KERATOSES
BASAL CELL CARCINOMA
DYSPLASTIC NEVUS OF SKIN
ECZEMA
MELANOMA
BASAL CELL CARCINOMA
OTHER:_____

DO YOU WEAR SUNSCREEN? YES NO
IF YES, WHAT SPF? _____
DO YOU TAN IN A TANNING SALON? YES NO

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

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:** _____

PRIVATE AND CONFIDENTIAL WITHOUT PREJUDICE. NOT FOR PUBLICATION.

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 result in adverse drug interactions or allergic reaction or other judgment error.

Please initial after reading this page: _____

South Coast Dermatology Institute

INFORMED CONSENT FOR TELEMEDICINE SERVICES

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

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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**

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