EL CENTRO DERMATOLOGY & LASER CENTER

PATIENT INFORMATION

Name: _____ □Male □Female Social Security Number:_____

Address/City/State/Zip:_____

Date of Birth : _____Age: _____ Email:_____

Cell Phone:_____Home Phone:_____ Work Phone:_____

Employer:_____ Occupation:_____

Can leave a message at (check one or more): □home □work □cell □email

□Emergency Contact Name:_____Relation:_____ Phone Number:_____

Marital Status: □Married □Single □Minor Child □Divorced □Widowed

HOW DID YOU HEAR ABOUT OUR DERMATOLOGY, LASER AND COSMETIC SERVICES? PLEASE MARK ALL THAT APPLY:

□web search
□billboard
□radio
□facebook
□website
□newspaper
□magazine
□television
□in-office ad/brochure
□instagram
□tattoo parlor referral:_____
□friend/family referral (name):_____
□other (please specify):_____
□doctor referral (name):_____
□been a patient here before

MEDICAL INSURANCE INFORMATION

We will need a copy of all primary and secondary insurance cards. Please bring your card to the receptionist along with this form so a copy can be made

INSURANCE GUARANTOR (PARENT, SPOUSE, OR RESPONSIBLE PARTY) INFORMATION IS NEEDED ONLY IF THE PATIENT IS NOT THE SUBSCRIBER TO THE INSURANCE

Name of Guarantor:_____ Relationship to the patient:_____

Address: _____

Guarantor Date of Birth: _____ Gurantor Social Security Number:_____

Guarantor home phone number:_____ Guarantor Cell Phone:_____

Guarantor Employed by:_____ Guarantor Work Phone:_____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signature:_____Date:_____

EL CENTRO DERMATOLOGY & LASER CENTER

OFFICE PAYMENT FINANCIAL POLICY

As Part of our commitment to offer excellent medical and professional care to you and your family, we would like to present our office payment policy in order to minimize misunderstandings about our policy. Our fees and methods of payments are comparable with physicians in the area. This includes payment for the office visit and any tests that are performed. We commonly require payment at the time of check in.

SELF-PAY FINANCIAL POLICY

1. We require that 100% of the first/initial visit fee be paid at the time care is rendered.
2. Payment plans can be arranged. Please make an appointment with our patient care representative.
3. Treatment may not be administered to any patient whose balance exceeds $250.00.

COMMERCIAL, HMO, AND PPO INSURANCE FINANCIAL POLICY

1. We need for you to understand that your insurance coverage is just that, YOUR coverage. It does not release you from any financial obligations for the services we rendered to you. It is YOUR responsibility to know your coverage benefits. (Examples: Deductible, co-insurance, co-pays, etc.). This information will assist you in making educated decisions regarding your treatment and financial obligations.
2. If you are a new patient, or your insurance ever changes, you must furnish us with a copy of your current insurance card prior to treatment. Without this information, you will be considered as a cash patient.
3. If an HMO plan insures you, it is your responsibility to contact your Primary Care Physician to obtain the necessary referral or authorization number.
4. Our office has no knowledge of the exact amount your insurance carrier will allow. We will make every attempt to bill and collect the allowed amount from the insurance company. If for any reason our insurance company does not cover treatment within 90 days, you will be billed for all outstanding dates of service. We will collect 100% of the allowed rates that should be applied to your insurance policy's deductible. If allowed rates are not known, there will be a minimum of 20% of the bill collected at the time of service.
5. Once ALL insurance payments have been received and it is deemed you have made an overpayment, we will refund any overpayment to you promptly.

MEDICARE POLICY

1. 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. It is YOUR responsibility to know your secondary/supplemental insurance coverage.
2. 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.

3. 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.

MISCELLANEOUS INFORMATION

1. We accept cash, debit cards (with credit card logo), check, Visa, MasterCard, and Discover.
2. We require that amount due be paid at the time of service. Please make an appointment with our patient care representative to discuss any financial questions or concerns.
3. The fee for a returned check is $15.00. If you submit a check with insufficient funds, your professional treatment may be suspended until your balance is paid. Checks will no longer be accepted from a patient who has had a returned check.
4. Any laboratory (bloodwork, x-rays, pathology, etc.) test which requires an outside lab company will be billed separately by that lab company.
5. You must present a current insurance card and ID at the time of your visit.
6. Every effort will be made to ensure that you receive timely communications relating to your account; however it is your responsibility to inform us of any change in name, address, phone or insurance coverage.
7. Statements are sent every 30 days
8. It is against federal law if physicians don’t bill patients for the balance due after an insurance company payment.
9. Any patient account balance over 90 days past due, who does not have a financial payment contract, will be turned over to an outside collection agency. This also includes any patient account balances that have defaulted from their financial payment contract.
10. There is a $35.00 fee to copy records, unless we are copying for a sub-specialty appointment that we refer.
11. All cosmetic procedure fee(s) will be collected in full at the time of service. Payment methods are cash, personal check or credit card (Visa, MasterCard, or Discover).
12. Your insurance will be billed under Anthony Huynh Medical Group, Inc. El Centro Dermatology and Laser Center is registered as a DBA (Doing Business As) under Anthony Huynh Medical Group, Inc.
13. We reserve the right to change our financial policy at any time.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Signature:_____Date:_____

EL CENTRO DERMATOLOGY & LASER CENTER

ACKNOWLEDGEMENT OF OFFICE POLICIES

Patient Name: _____ Date of Birth: _____

Please review and initial each policy listed below:

_____ **Receipt of Notice of Privacy Practices:** Effective date 6/1/2015: I acknowledge that I will receive a copy of the "Notice of Privacy Practices" upon request. I have had the opportunity to review the Notice of Privacy Practices of Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology and Laser Center. (This document is available at our front desk or on www.elcentrodermatology.com) I may request additional copies at any time. If there is any amended "Notice of Privacy Practices," they will be available upon request at my next appointment.

_____ **Consent to Treatment:** The nature of many if not most dermatology consultations is that unclothed skin and body examination is indicated. Often another El Centro Dermatology and Laser Center staff member may be present, in general this is for both the patient and provider's protection and to assist in the patient's care. I give my consent for examination with or without another El Centro Dermatology and Laser Center staff member present, and treatment including biopsies and excision and injections, as discussed with my provider. Each scheduled medical appointment in our office is considered an office visit and will be billed to your insurance. Please note that any procedure performed in the office may be billed separately and in addition to the office visit fee.

_____ **Release of Medical Information:** I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, and prescriptions. If at any time you should need a copy of your complete medical record, we require a written release to be signed and dated. The form is available from our front office staff. Please allow 10-15 business days to complete your request. If your request is urgent, please ask to speak with the practice manager to expedite your request. If one of your other treating physicians requires records for continuation of care, their office may request these specific items be faxed to them directly.

□**Do** □**Do Not** **Authorize Release of Medical Information to Family Members:** □ I Do □ I Do Not wish to authorize El Centro Dermatology and Laser Center and its designated representatives to release my medical information to my spouse, parent, or guardian.

Name: _____ Relationship: _____ Phone #: (___) _____
Name: _____ Relationship: _____ Phone #: (___) _____

_____ **Unaccompanied Minors (Under 18 Years Old):** I understand that El Centro Dermatology and Laser Center is unable to treat unaccompanied minors unless prior consent is obtained from a parent or legal guardian. Non-emergency treatment will be denied unless we have this consent. New patient minors must have a parent or legal guardian present for the new patient exam. Existing patients, who are under the age of 18, may provide us with a signed Minor Consent Form (available from our front office staff). I understand that I must make arrangements for payment of copay or other fees as needed at the time of service.

_____ **Proof of Identity:** El Centro Dermatology and Laser Center requires proof of identity on file. I understand that I will be asked to provide a photo ID such as a driver's license at check-in. This copy will be kept in your private medical record to confirm your identification.

_____ **I authorize you to send me practice related emails.**

By signing this Acknowledgment of Office Policies you acknowledge that you have read, understand and accept the above policies.

Signature:_____**Date:**_____

DIGITAL CONTENT RELEASE

Federal law guarantees a patient's right to maintain privacy of medical information. Photographs taken before, during and after medical procedures may be considered part of the medical information.

I hereby authorize Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, Dr. Anthony Huynh, Dr. Diana Dang, Dr. Fred Shahan and staff representatives, the use of all DIGITAL CONTENT in the form of illustrations, photographs, or other imaging records created in my care, taken of me in conjunction with treatment. Subject to the Scope of Release set forth below, I release Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, Dr. Anthony Huynh, Dr. Diana Dang, Dr. Fred Shahan and staff representatives the right to these photographs, and I consent to the copyright, publication and use of such photographs.

Scope of Digital Content Release - I authorize the following uses of these photographs:

[Please check one of the following]

□ **A**. **ANY AND ALL USES.** This includes, but is not limited to: advertising, publicity or promotion in print, visual, or electronic media; communications to physicians; publication in medical journals and/or textbooks for physician education; and for use in physician-to-physician lectures and patient education. Further, I release and discharge Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, Dr. Anthony Huynh, Dr. Diana Dang, Dr. Fred Shahan and staff representatives, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

□ **B.** **LIMITED MEDIA USE** by Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, Dr. Anthony Huynh, Dr. Diana Dang, and Dr. Fred Shahan. Internal use for research and development and quality control; communications to physicians; publication in medical journals and/or textbooks for physician educations; and for use in physician-to-physician lectures.

□ **C.** **FOR MEDICAL RECORD ONLY**. This will limit use of any digital content produced of me to Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, involved office staff, Dr. Anthony Huynh, Dr. Diana Dang, Dr. Fred Shahan and staff representatives.

I understand that once my photographs have been disclosed to Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, Dr. Anthony Huynh, Dr. Diana Dang, Dr. Fred Shahan and staff representatives, the photographs will no longer be protected by federal privacy laws. Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, Dr. Anthony Huynh, Dr. Diana Dang, Dr. Fred Shahan and staff representatives, will not use the photographs except as permitted on this authorization form.

I will not be identified by name in any of the published materials. I have the right to revoke this authorization in writing at any time through a written revocation Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, Dr. Anthony Huynh, Dr. Diana Dang, Dr. Fred Shahan and staff representatives. I hereby release Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, Dr. Anthony Huynh, Dr. Diana Dang, Dr. Fred Shahan and staff representatives, its successors, affiliates and assigns, from any claim, demand, cause of action, or proceeding of whatever nature arising out of any use, publications and/or distribution of my photographs in accordance with the terms of this authorization. I give this Authorization and Release freely and voluntarily. I understand that my physician will provide the service(s) agreed upon even if I do not sign this form.

I certify that I have read this release carefully and fully understand its terms. If I have any questions I can contact Anthony Huynh Medical Group, Inc. DBA El Centro Dermatology, Dr. Anthony Huynh, Dr. Diana Dang, or Dr. Fred Shahan at 760-337-8500.

If under 18, guardian or parent must sign.

Signature:_____**Date**_____

Printed Name:_____

EL CENTRO DERMATOLOGY & LASER CENTER

REASON FOR TODAY'S VISIT

(please check as many as you are interested in):

□**Referred by a physician for the following problems (please list your physician and skin problems)**:

_____

_____

□**Skin exam (please list any particular growths you are concerned with):**

_____

□**Other (please describe):** _____

Where is it? _____

How long have you had it? _____

Are you using anything for it? _____

□**Follow up visit (please list skin problem)**

_____

□**Laser Tattoo Removal (please list what areas you are thinking about treating):**

_____

□**Laser Skin Rejuvenation for Wrinkles, Brown Spots, or Acne Scarring**:

_____

□**Skin care consultation (please list your skin care interest):**

- □ Skin Care Recommendations for Oily or Acne Prone Skin
- □ Skin Care Recommendations for Dry/Sensitive Skin
- □ Skin Care Recommendations for Combination Skin

_____

□**Sunscreen recommendations:**

_____

□**Botox or Restylane (wrinkle fillers and lip injections)**

_____

Dermatology Medical History

Patient: _____ Date of Birth::____/____/____ Today's Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	**YES**	**NO**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	**YES**	**NO**
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:
Have you ever had skin cancer? ❑ YES ❑ NO
Has anyone in your family had skin cancer? ❑ YES ❑ NO
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____
Do you have problems with healing ❑ YES ❑ NO
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Topical Neosporin ❑ Other _____

Social History:
Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____
Do you smoke? ❑ YES ❑ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS) ? ❑ YES ❑ NO

Please answer the following questions:
(Women) Are you pregnant? ❑ YES ❑ NO Due Date: ___/___/___
What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient ❑ Medical Assistant _____ Initials

_____ ___/___/___
Signed by Patient Date

_____ ___/___/___
Reviewed by Date