PURE
DERMATOLOGY & COSMETIC CENTER

New Patient Paperwork

Name (Last, First, MI): _____ ◯ Jr ◯ Sr
Date of Birth: _____ Sex: ◯ M ◯ F ◯ Married ◯ Divorced ◯ Single ◯ Widowed
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email: _____
Occupation: _____Employer Name: _____
Work Address: _____

Primary Care Physician: _____ Telephone: _____
Primary Care Physician Address/City: _____

Who Referred you to our Office ? Check or explain: ◯ Dr. _____
◯ Insurance Plan: _____ ◯ Family/Friend: _____
◯ Hospital: _____ ◯ Google ◯ Yelp ◯ Other (Please specify): _____

Insurance Information -- Guarantor Information -- ◯ Check here if same as patient
Responsible Party: _____ Date of Birth: _____
Address: _____ City: _____
State: _____ Zip Code: _____ Patient's Social Security #: _____
Daytime Phone: _____ Occupation: _____
Employer Name: _____ Address: _____

Patient Basics: Meaningful Use
Preferred Language: ◯ English ◯ Spanish ◯ Other ◯ Decline
Race: ◯ White ◯ American Indian/Alaska Native ◯ Asian ◯ Black/African American
◯ Native Hawaiian/Other Pacific Islander ◯ Other ◯ Decline
Ethnicity: ◯ Hispanic/Latino ◯ Not Hispanic/Latino ◯ Unknown ◯ Decline

Confirm your Pharmacy name and City: _____
Pharmacy address & phone number: _____

Emergency Contact
Name: _____ Relationship to Patient: _____
Phone Number: _____

Treatment Consent
I GIVE MY CONSENT FOR EXAMINATION AND TREATMENT.
The nature of many if not most dermatology and/or cosmetic consultations is that unclothed skin and body examination is indicated. Often another Pure Dermatology 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 Pure Dermatology staff member present, and treatment including biopsies and excision and injections, as discussed with my provider.

Signature: _____ Date: _____

Financial and Billing Policies

Thank you for choosing Pure Dermatology & Cosmetic Center. We are committed to providing excellent skin health care in a patient focused environment. We are contracted with several insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments, deductibles, and other provisions. If you have any questions, we encourage you to call your health plan's member services department. Their number should be listed on the back of your insurance card.

We will submit claims to your insurance company. Because of this, we make a copy of your insurance card at every visit. We also ask that you inform us if your person or insurance information changes. The lack of current information may cause delays in care and make you personally responsible for the cost of the entire visit. If your office visit precedes the effective date of your insurance coverage or is not covered by your insurance, you will be held responsible for all fees incurred as a result of your visit.

Co-payments, Deductibles, and Co-Insurance
Co-payments are due at the time of your office visit. Under the terms of our contract with various insurance plans, we cannot waive any co-payments, deductibles, or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience, we accept cash, checks, all major credit cards, and Care Credit.

Payment is required for all services at the time they are rendered. If you are in an insurance plan that we participate in, in general, only applicable co-payments and deductibles will be collected at the time of the service and we bill insurance for you as a courtesy. However, we do reserve the right to collect full payment from the patient for any procedures performed. The patient is responsible for any/all charges not paid by any insurance company including third party laboratories or pathologists. I agree to make in full prompt payment to Pure Dermatology when billed for any/all charges not covered. Further, I authorize payment directly to the provider for medical insurance benefits payable to me under the terms of my policy. We do reserve the right to change our financial policy at any time.

Assignment of Payment
I hereby authorize payment directly to Pure Dermatology of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

Outside Services
To provide the best care possible, Pure Dermatology & Cosmetic Center may send specimens to an outside source for processing. Examples of these services are pathology and laboratory testing. If we send specimens to an outside office, you will receive a separate billing statement from the outside pathologist or laboratory. These charges will be in addition to those services services rendered by Pure Dermatology.

Financial Policies Continued

Cosmetic Procedures
Elective cosmetic procedures are not covered by insurance companies. You are financially responsible for all charges associated with elective, cosmetic and non-covered procedures. Patients who have a cosmetic consultation will receive credit in the amount of the consult toward their cosmetic procedure.

Late Charges and Other Fees
Accounts with balances over 90 days old are subject to late fees
Accounts referred to a collection agency may be subject to a $50.00 collection fee, attorney fees, and/or the percentage allowed under California state law.
There is a $25.00 fee for all checks returned for NSF (non-sufficient funds).

Office Visits
If you are unable to keep your general dermatology, follow-up, or cosmetic appointment , we ask that you notify our office by phone at least 24 hours in advance. We often have patients who can be scheduled in your appointment slot if you notify us of the cancellation with sufficient time. If your cancellation is within 24 hours of your appointment, you may be charged a $50.00 missed appointment/late cancellation fee. If you continue to miss appointments, you may be dismissed from this practice.

Surgical Procedures
If you are scheduled for any surgical procedure, please note, we require at least 72 hours notice to either cancel or reschedule your procedure so that we may accommodate another patient in your appointment slot. A notice less than 72 hours will result in a $100.00 late cancellation fee.

I have read, understand, and agree to the above Financial and Billing Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles are my responsibility.

I authorize my insurance benefits to be paid directly to Pure Dermatology & Cosmetic Center.

I authorize Pure Dermatology to release pertinent medical information to my insurance company when requested or when needed to obtain authorization for a procedure or to facilitate the payment of a claim. I have given complete and accurate information and agree to inform Pure Dermatology of any changes regarding my person billing information or my insurance billing information.

PRINT NAME: _____

PATIENT SIGNATURE:_____ DATE: _____

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Past Medical History (Please check all that apply)

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Bone Marrow Transplantation
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ High Cholesterol
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV / AIDS
- ❑ Thyroid Problems
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ **NONE**
- ❑ Other Medical History not specified: _____

Past Surgical History (Please check all that apply)

- ❑ Appendix Removed
- ❑ Bladder Removed
- ❑ Mastectomy (Right, Left, Bilateral)
- ❑ 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
- ❑ Mechanical Valve Replacement
- ❑ Biologic Valve Replacement
- ❑ Heart Transplant
- ❑ Testicles Removed (Right, Left Bilateral)
- ❑ Prostate Biopsy
- ❑ Prostate Removed: Prostate Cancer
- ❑ TURP: Prostate Removal
- ❑ Hysterectomy: Fibroids
- ❑ Hysterectomy: Uterine Cancer
- ❑ Joint Replacement, Knee (Right, Left, Bilateral)
- ❑ Joint Replacement, Hip (Right, Left, Bilateral)
- ❑ Joint Replacement within last 2 years
- ❑ Kidney Biopsy (Nephrectomy)
- ❑ Kidney Removal (Right, Left)
- ❑ Kidney Stone Removal
- ❑ Kidney Transplant
- ❑ Ovaries Removed: Endometriosis
- ❑ Ovaries Removed: Ovarian Cancer
- ❑ Ovaries Removed: Cyst
- ❑ Spleen Removed
- ❑ **NONE**

Other Surgical History not specified: _____

Skin Disease History (Please check all that apply)

- ❑ Acne
- ❑ Actinic Keratosis
- ❑ Asthma
- ❑ Basal Cell Skin Cancer
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever / Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ Blistering Sunburns
- ❑ Dry Skin
- ❑ **NONE**

Do you wear sunscreen? ◯ Yes ◯ No If yes, what SPF?: _____
Do you tan in a tanning salon? ◯ Yes ◯ No
Do you have a family history of Melanoma? ◯ Yes ◯ No. If yes, which relative(s)?_____

Medications (Please list all current medications)

_____

_____

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Allergies (Please list all allergies)

_____

_____

Social History (Please check all that apply

Please confirm your smoking status: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

If you're a smoker, would you like help quitting? ☐ Yes ☐ No

Reason for today's visit (chief complaint): _____

How long have you had this problem?: _____

What parts of your body are affected?: __:_____

How does this problem bother you? (symptoms): _____

What treatments have you received for this problem?: _____

Is your problem (please check one of the following): ○ Worsening ○ Stable ○ Improving

○ Explain: _____

Review of Systems: Are you currently experiencing any of the following?

- ❑ Problems with bleeding
- ❑ Frequent infections
- ❑ Problems with healing
- ❑ Problems with scarring (hypertrophic or keloid)
- ❑ Rash
- ❑ Immunosuppression
- ❑ Hay Fever
- ❑ Heartburn / Indigestion
- ❑ Chest Pain
- ❑ Heart Palpitations
- ❑ Fever or Chills
- ❑ Night Sweats
- ❑ Unintentional Weight Loss
- ❑ Weight Loss
- ❑ Fatigue
- ❑ Thyroid Problems
- ❑ Hormonal Changes / Problems
- ❑ Sore Throat
- ❑ Mouth Ulcers
- ❑ Ringing in Ears
- ❑ Blurry Vision
- ❑ Abdominal Pain
- ❑ Bloody Stool
- ❑ Bloody Urine
- ❑ Problems with Urination
- ❑ Constipation
- ❑ Nausea
- ❑ Vomiting
- ❑ Joint Aches
- ❑ Muscle Weakness
- ❑ Neck Stiffness
- ❑ Back Pain
- ❑ Ankle Swelling
- ❑ Hands/Fingers Sensitive to Cold
- ❑ Cough
- ❑ Shortness of Breath
- ❑ Coughing up Blood
- ❑ Anxiety
- ❑ Depression
- ❑ Dizziness
- ❑ Headaches
- ❑ Confusion
- ❑ Memory Loss
- ❑ Numbness
- ❑ Loss of Consciousness
- ❑ Insomnia
- ❑ Seizures
- ❑ Diarrhea
- ❑ **NONE**

Other Symptoms not specified: _____

Alerts (Please check all that apply)

- ❑ Allergy to Adhesive
- ❑ Allergy to lidocaine
- ❑ Allergy to topical antibiotics
- ❑ Artificial heart valve
- ❑ Blood thinners
- ❑ Defibrillator
- ❑ MRSA
- ❑ Artificial joint replacement
- ❑ Pacemaker
- ❑ Require antibiotics prior to a surgical procedure
- ❑ Rapid heartbeat with epinephrine
- ❑ Are you pregnant or currently trying to get pregnant
- ❑ **NONE**

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DIGITAL PHOTO CONSENT

Federal law guarantees a patient's right to maintain the privacy of medical information. Photographs taken before, during, and after medical procedures may be considered part of the medical information. Please note that the release of all photographs, videos, illustrations, or otherwise is addressed at the time of taking your photographs for medical records kept with Pure Dermatology & Cosmetic Center.

PRINT NAME: _____

PATIENT SIGNATURE:_____ **DATE:** _____

In-office Use Only **PROVIDER SIGNATURE:** _____

Notice of Privacy Practices

_____ (initial) I authorize employees from Pure Dermatology to leave me a voicemail with Protected Health Information

Pure Dermatology employees may leave me a voicemail with Protected Health Information to the following number: _____

Please identify any individual(s) with whom Pure Dermatology employees may discuss your medical condition and/or financial information (optional):

❏ Medical Information ❏ Financial/Billing Information
Name: _____ Relationship: _____
Phone Number: _____

❏ Medical Information ❏ Financial/Billing Information
Name: _____ Relationship: _____
Phone Number: _____

To our patients, this notice describes who health information about you (as a patient of Pure Dermatology) may be used, disclosed, and how you can obtain access to your health information. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

Pure Dermatology is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities & health oversight agencies that are authorized by law to collect info.
2. Lawsuits and similar proceedings in response to a court of administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to the health & safety of another individual or the public. These disclosures would only be made with persons or organizations who are able to help prevent such a threat.

5. If you are a member of U.S. or foreign military (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications: You can request that Pure Dermatology communicate with you about your health & related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate all reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required by law to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient & medical/billing records, but not including psychotherapy notes. You must submit your request in writing to Pure Dermatology or contact the office for further information.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing & submitted to Pure Dermatology, or contact the office for further information. You must provide us with a reason that supports your request for amendment.
5. Right to copy of this notice: You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy at any time. To obtain a copy of this notice, contact our office.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office for further information.
7. Right to provide an authorization for other uses and disclosures: Pure Dermatology will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact Pure Dermatology.

HOAG HEALTH INFORMATION EXCHANGE (HIE)

We participate with HIE. HIE is an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law that protects your privacy. If you choose to opt out of the HIE, we will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to the HIE. To opt out of the HIE, please contact the Hoag Director of HIE by phone at 949-764-8722.

I hereby acknowledge that I have been presented with a copy of Pure Dermatology Privacy Practices.

PRINT NAME: _____

PATIENT SIGNATURE:_____ **DATE:** _____

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Cosmetic Questionnaire

We'd love to hear your cosmetic interests; Please select all that apply

- ❑ Facial Wrinkles
- ❑ Excessive Sweating - Hands, Feet, Underarms
- ❑ Acne / Acne Peels
- ❑ Dark Spot Corrector
- ❑ Skin Care Regimen Advice - Acne, Anti-Aging, Brightening)
- ❑ Dark Spot Corrector
- ❑ Unwanted Leg Veins
- ❑ Frequent Urination / Dryness / Low Libido
- ❑ Stretch Mark Reduction
- ❑ Rough / Dry Skin Exfoliation
- ❑ Unwanted Facial Veins / Redness
- ❑ Facial Rejuvenation with Fillers / Botox
- ❑ Hair Loss
- ❑ Laser Hair Removal - Lip, Face, Neck, Legs, Underarms, Bikini
- ❑ Removal of Unwanted Moles / Skin Tags
- ❑ Face / Cheek Rejuvenation with Laser / Vampire Lift
- ❑ Lip Enhancement
- ❑ Skin Tightening - Face, Neck, Chest, Arms, Thighs, Abdomen
- ❑ Pregnancy Skin Care
- ❑ Fat Reduction - Flanks "Muffin Top", Abdomen, Outer Thigh, Inner Thigh, Double Chin
- ❑ Other - Please Specify: _____

Consent for Photography / Authorization for Use and Disclosure

This form is to be used only for photographs taken for treatment for Pure Dermatology & Cosmetic Center's own healthcare operations, as allowed under the Federal Privacy Laws. The term "photograph" as used herein includes video or still photography, digital, any other format, and any other means of recording or reproducing images.

I hereby authorize the use or disclosure of photography or other purposes including research publication, outside education, marketing, and public relations (i.e. Pure Dermatology & Cosmetic Center publications, websites, printed materials, social media websites, etc.) If the photograph will be used for office marketing purposes, all measures will be taken to make the images **non-identifiable**. Pure Dermatology & Cosmetic Center will not share such photographs or images for any other purpose without my specific written consent. I and my successors or assigns hereby hold Pure Dermatology & Cosmetic Center, its employees or physician(s), and any other person(s) participating in my care harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge and agree to the terms and conditions of this document.

❑ Consent ❑ Decline

PRINT NAME: _____

PATIENT SIGNATURE:_____ **DATE:** _____