CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

Please submit completed 6 pages to:
Contour Dermatology and Cosmetic Surgery Center
42600 Mirage Rd BLd A1, Rancho Mirage, CA 92270
Or fax to (760) 318-8103

Patient Registration Form

Title: □ Mr. □ Mrs. □ Ms. □ Miss Marital: □ Married □ Single □ Widowed □ Dom. Partner

Legal Name: _____ □ Jr. □ Sr.
First *Middle* *Last*

Do we have your permission to:
Email you (non-medical) info, events and specials? □YES □NO If yes, Email: _____

Prefer to be called: _____ Date of Birth: _____/_____/_____ Sex: □ M □ F

Address:_____
Street# *Street Name* *Apt#*

_____
City *State* *Zip*

Home Phone: _____ Work Phone: _____ SSN: _____-_____-_____

Preferred Language: _____ Race: _____ Ethnicity: _____

Employer: _____
Name *Address* *Phone*

If Student: □ Full Time □ Part Time Name of School: _____

Emergency Contact_____ Phone _____ Relationship _____

Spouse: _____ Spouse's date of birth: _____/_____/_____

Pharmacy of choice _____ Phone _____

Primary Care Physician _____ **Referring Physician:** _____

City & State of Referring Physician: _____ Specialty: _____

Mailing address (if different from above):

_____
Street# *Street Name* *Apt#*

_____
City *State* *Zip*

PARENT OR RESPONSIBLE PARTY *(if different from patient)*
Name _____
Last *First* *M.I.*
Address_____
City *State* *Zip*
Home Phone _____ Work Phone_____ SS#_____-_____-_____

Date of Birth____/____/____ Sex: □ M □ F

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Do we have your permission to:

Leave a message on your answering machine at home? □YES □NO

Leave a message at your place of employment? □YES □NO

Discuss your medical condition with any member of your household? □YES □NO

If yes, whom: _____ Relationship _____

_____ _____

Patient Signature *Date*

CONTOUR DERMATOLOGY & COSMETIC SURGERY CENTER

Patient Name:_____ Birth Date:_____

Dermatology Medical History

_____ ←INITIAL HERE AND SKIP THIS PAGE IF HISTORY WAS RECENTLY UPDATED ONLINE

Date: _____ Reason for today's visit:
_____

ALLERGIES Are you allergic to any medications? □ YES □ NO If yes, list:_____

- Have you ever had dental anesthesia (Novacaine)? □ YES □ NO Any bad reaction? □ YES □ NO

FAMILY HISTORY

- Has anyone in your family had skin cancer? □ YES □ NO If yes, who? _____

BILLING ALERT Eisenhower/Keenan health insurance? □ YES □ NO (They will not pay for pathology processed outside of Eisenhower)

MEDICATIONS

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1._____ 3. _____

2. _____ 4. _____

PAST MEDICAL HISTORY

- Have you ever had skin cancer? □ YES □ NO If yes, describe:_____
- Do you have a history of Melanoma? □ YES □ NO If yes, describe:
  _____
- Do you develop skin rashes in reaction to □ Medications □ Food □ Environment? Please explain
  _____
- When you are exposed to sun do you: □ Tan only □ Tan & burn □ Burn
- Do you have a history of specific skin diseases? □ YES □ NO If yes, what?
  _____
- List any other diseases or conditions:
  _____

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

	YES	NO		YES	NO
Arthralgia	□	□	Gastrointestinal Problems □		□
Arthritis/Joint Deformity	□	□	Heart Attack	□	□
Artificial Joints	□	□	Heart Murmur	□	□
Asthma	□	□	High Blood Pressure	□	□
Bladder Problems		□ □	Inflammation of Veins	□	□
Bleed Easily	□	□	Irregular Heartbeat	□	□
Blood Clots	□	□	Kidney Problems	□	□
Bronchitis	□	□	Limited Motion in Joints	□	□
Chest Pain	□	□	Morning Cough	□	□
Chronic Cough	□	□	Nausea, Vomiting, Diarrhea when taking Antibiotics	□	□
Convulsions, Epilepsy or Seizures	□	□			
Currently Breast Feeding	□	□	Pacemaker	□	□
Currently Pregnant	□	□	Phlebitis	□	□
Diabetes		□ □	Shortness of Breath	□	□
Emphysema	□	□	Stomach Absorptive Disorder	□	□
Excessive Thirst/Hunger	□	□	Thyroid Problems □		□
Fainting	□	□	Wheezing	□	□
Frequent Burning During Urination		□ □	Yeast Infection when taking Antibiotics	□	□

SURGICAL HISTORY

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

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Patient Name:_____ Birth Date:_____

SOCIAL HISTORY

- Do you drink alcohol? □ YES □ NO If YES _____ drinks per day
- Have you had or have you been exposed to HIV (AIDS)? □YES □NO
- Do you use IV drugs? □ YES □ NO If YES, what? _____ How much? _____
- Do you smoke? □ YES □ NO If YES, how much? _____
- What is your occupation? _____ What are your hobbies? _____

Completed by: □ Patient
□ Medical Assistant _____
Initials

_____
Signed by Patient *Date*

_____
Reviewed by *Date*

INSURANCE INFORMATION

INSURANCE INFORMATION ***(Please present insurance card at time of check in.)***

Primary Insurance Name _____
Ins. Address _____
Name of Insured _____
Date of Birth of Insured _____
Insured ID # _____
Group # _____
Employer Name _____
Employer Address _____
Employer Phone _____
Relationship to insured _____

Secondary Insurance Name _____
Ins. Address _____
Name of Insured _____
Date of Birth of Insured _____
Insured ID # _____
Group # _____
Employer Name _____
Employer Address _____
Employer Phone _____
Relationship to insured _____

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, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of any information needed to act upon this request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges of the physician for his/her services. I understand I am responsible for any remaining balances

I have read and understand the financial policy (please see attached) and agree to payment for services rendered and not covered by the insurance providers listed above.

_____ _____
Signature of patient/ legal guardian/ policy holder *Date*

HOW DID YOU HEAR ABOUT US?

We would appreciate your response in following section so that we may better direct our advertising.

Yellow Pages	**Newspapers**	**Magazines**	**Other Sources**
□ Verizon	□ Desert Sun	□ Palm Springs Life	□ Friend:
□ Desert Pages	□ The Desert Woman	□ The Bottom Line	□ Physician:
□ Online Yellow Pages	□ Hi-Desert Star	□ The Desert Woman	□ Internet Site:

Patient Name:_____ Birth Date:_____

□ Yucca Valley Yellow
□ User Friendly Yellow
□ Other:

□ Other:

□ Other:

□ Dr. Lecture (where?):
□ Community Expo:
□ Insurance Provider Directory:
□ Other:

HEALTH ISSUES THAT INTEREST YOU

Please check all that apply:

□ Botox Cosmetic Therapy
□ Beta-lift & Glycolic Peels
□ Facial Fillers
□ Skin Rejuvenation
□ Retin-A or Renova
□ Dermabrasion
□ Reducing Wrinkles
□ Cosmetic Consultation
□ Hair Restoration
□ Tattoo Removal
□ Varicose Veins

□ Acne
□ Makeup (to conceal blemishes)
□ Skin care products / Sunscreens
□ Plumping the Lips
□ Lipodystrophy Treatments
□ Birthmarks
□ Liver spots / age spots
□ Fraxel Laser Treatments
□ Eyelid reductions (Blepharoplasty)
□ Longer eyelashes / Latisse
□ Face Lift, Neck Lift, Brow Lift

□ Laser Resurfacing
□ Laser Treatments
□ Liposuction / Fat Transfers
□ Laser Hair Removal
□ Spider Vein Treatments
□ Removing Facial Veins
□ Cellulite Removal
□ Lasers for Darker Skin Types
□ Cellulite Removal
□ Mini Facelift
Other please specify:

CONTOUR DERMATOLOGY & COSMETIC SURGERY CENTER

Patient Name:_____ Birth Date:_____

FINANCIAL POLICY

Dear Patient,

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. We are currently contracted with the following PPO insurance carriers: **Medicare, Blue Cross, Blue Shield, Blue Cross/Blue Shield, Cigna, Aetna, CNN, and United Healthcare, HealthNet, PacifiCare**. Additionally,

1. The patient understands that all charges for services in this office are ultimately their responsibility.
2. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:
    a. The annual deductibles
    b. Copayments
    c. Charges for noncovered or cosmetic services

    In the event that we are not aware of a charge that is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

3. We are Medicare participating providers. We will bill Medicare. You will be responsible at the time of service for payment of:
    a. The annual deductibles
    b. Copayments
    c. Charges for noncovered or cosmetic services*
    *You will be asked to sign a Waiver of Liability Form in the event that a service is provided which we know is not covered by Medicare.

    If you have Medicare as well as secondary coverage with a commercial plan that is an insurance company with which we have no contract, we will file a claim to your secondary/ supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance. Payment is due 10 days of receipt of statement.

4. For patients who have insurance coverage through Eisenhower Medical Center and/or Keenan & Associates, managed by Blue Cross of California: We send our pathology/biopsy specimens to an outside vendor associated with The University of California, Los Angeles. Eisenhower employee's insurance will not cover these fees. If you choose to have the specimens sent to our pathologist, you will be billed directly by them at approximately $150 per specimen. If you choose to have Eisenhower Medical Center process your pathology, please ask your care provider to make those arrangements with you. We do not automatically send your pathology to Eisenhower for processing unless you explicitly make that request during each visit.

5. For patients who have insurance coverage with an insurance carrier with which we do **not** have a contractual relationship, please note the following:

a. As a courtesy, we will file both your primary and secondary insurance. If we do not receive payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.
b. If we receive payment from the primary, we will file a claim with your secondary. If we do not receive payment from your primary carrier within 60 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

c. If you only have primary insurance (i.e., no secondary/supplemental coverage), you will be asked to prepay 35% of the entire bill. Any amount not paid by your insurance company will be billed to you.

Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. The entire balance remaining after your primary carrier has paid will be billed to you and is due and payable 10 days after receipt of the statement.

6. We will send statements directly to patients for balances on cosmetic procedures as well as insurance deductibles and copay amounts stated by insurance carriers.
   a. Patients will be subject to a $25.00 processing fee for returned checks.
   b. Patients may be subject to a $10.00 monthly service charge for non-payment of their monthly statement.

7. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account.

8. If you need to reschedule or cancel an appointment, please notify us at least 48 hours in advance or you may be subject to a $30.00 "no-show" fee.

9. Notice to Medi-Medi Patients:
   Our office participates with Medicare, but **not** Medi-Cal. As a professional courtesy, we will write off the amount applied to co-insurance. However, Medi-Medi patients are responsible to pay any amount applied toward their annual Medicare deductible. This means you may be billed for up to $155. If you are not sure if your Medicare deductible has been met, please contact Medicare for more information. If your deductible has not been met prior to receiving care at our office, you will be responsible for payment.

I understand that I am ultimately responsible for charges for services incurred during my office visit. My signature below signifies that I understand Contour Dermatology's financial policy and my responsibility regarding charges incurred in this office.

_____ ____ /____ /____

Patient signature **Date**

_____ _____ ____ /____ /____

Witness Name **Witness signature** **Date**

CONTOUR DERMATOLOGY & COSMETIC SURGERY CENTER

Patient Name:_____ Birth Date:_____

Notice of Privacy Practices
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, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you 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