dsp
DERMATOLOGY SPECIALISTS OF PASADENA

Patient's Name (Last,First): _____ Date of Birth: _____/_____/_____

Address _____

City _____ State _____ Zip _____

Sex: M /F / T Preferred Language: _____ Ethnicity:_____

Marital Status: O Married / O Partner / O Single / O Divorced / O Other

O Home Phone _____

O Work Phone _____

O Mobile Phone _____

O Email _____

Emergency Contact:_____ _____ _____
Name Relation Phone No.

Is it ok to leave a detailed message: O YES / O NO

Is it ok for office to send appointment reminders: O YES / O NO

Employment: _____ / _____ / Retired / Student
Employer Occupation/Profession

Primary Physician/Provider: _____

Referring Physician/Provider: _____

Preferred Pharmacy: _____

Address:_____

City or Zip code:_____

Phone No.:_____

PRIMARY INSURANCE

Policy Holder's Name:_____Relationship to patient:_____
Policy Holder's Date of Birth: _____/_____/_____
Insurance Company Name:_____
Member ID:_____ Group ID:_____

SECONDARY INSURANCE (IF APPLIES)

Policy Holder's Name:_____Relationship to patient:_____
Policy Holders Date of Birth: _____/_____/_____
Insurance Company Name:_____
Member ID:_____ Group ID:_____

NOTICE OF PRIVACY ACT PRACTICES

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide you, the patient or personal representative, a copy of our Notice of privacy practices and for you to sign as an acknowledgement of receipt.

Patient Signature:_____ Date:_____

***Concerning matters of my health, lab results, and appointments, I, the patient/patient representative give permission for Dr. Zohrabian or members of her staff to speak to and share my information with:

___I do **NOT** want to share my information with anyone.

Same as Emergency Contact: O Yes / O No If different/additional:_____

Name: _____ Relationship: _____

The above information is accurate to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dermatology Specialists of Pasadena/Narineh Zohrabian MD Inc. or insurance company to release any information required to process my claims.

Patient Signature / Patient Representative: _____ Date: _____

Please remember that your health insurance is a contract between you and your insurance company. It is **YOUR** responsibility to know your health plan benefits, including co-payment amounts, deductibles, co-insurance, and lab contracts. As a service to you, we will submit a claim to your insurance company for all visit charges, but we do not share in the contract between you and your insurance company. You are responsible for any charges not covered by your insurance plan. Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service. A photocopy of your ID and insurance card is needed by our billing department to assist you in filing your claim. It is the patient's responsibility to inform this office if your insurance requires pre-certification or pre-authorization of services prior to scheduling of such services. The patient will be responsible for services denied by insurance due to "No Eligibility", "Non-Covered Service", "Pre-authorization/Certification Not Obtained". Statements are released after your insurance pays, denies, or non-payment by your insurance.

In Network Coverage: For insurance companies that we are contracted with, we will determine your copay due at the time of the visit. co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE.

Out of Network Coverage: For these plans, your payment is due at the time of the visit. You are responsible for the charges of the provided services, which may be higher than the similar services for an in-network provider. co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. Feel free to be a Self-Pay patient and submit your bill for reimbursement at your insurance company.

Co-payments, deductibles, and fees: co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. Failure to produce payment may result in your appointment being rescheduled. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to patients, you, the insured.

Self-Pay Patients: Self-pay or uninsured patients are responsible for payment at the time of service.

Non-Covered Services: Cosmetic services cannot be submitted to insurance and payment in full is due at the time of service by credit card or cash only. No checks will be accepted for cosmetic services.

Returned Check Fee: All returned checks will be charged a $30 processing fee.

By signing the agreement, you understand that once the health plan has paid their portion for my care that you will receive an Explanation of Benefits (EOB). The health plan EOB will state any balance remaining to be paid by the patient. *Dermatology Specialists of Pasadena* may send you a billing statement when they receive a copy of the EOB. Charges will be made ONLY after the claim has been adjudicated by your insurance and you will have received an EOB from your insurance detailing the amount billed. Circumstances when you may get a bill include but are not limited to missed co-payments, deductibles and co-insurance, and non-covered services and/or denial of services.

Medicare Patients: We will bill Medicare for you. We must have your signature on file and we will also bill secondary insurance carriers for you. All co-payments are due at the time of service. The patient will be responsible for any balance not paid by Medicare and secondary insurance.

Outstanding Balances: If your account is not paid within 30 days of receiving the first bill, you will receive a phone call. If the account balance is not paid in 60 days, your account will be turned over to a collection agency and assessed a $50 processing fee. Failure to pay bills will result in dismissal from the practice.
Pathology/Laboratory Services: *Dermatology specialists of Pasadena* uses third parties for our laboratory work and pathology services. You/your insurance will receive an additional bill from the lab service provider (Quest, LabCorp, etc). We are unable to adjust these charges as they are provided by a separate entity.

Missed Appointments: Please provide at least 24 hours notice to cancel an appointment. We do this so your appointment slot can be offered to another patient in need of attention. After a missed appointment, you will be asked to keep a credit card on file prior to scheduling your next appointment. You will not be charged unless you "no show" for the subsequent appointment. You will be charged a $30 fee if you fail to keep your appointment or cancel with less than 24 hours notice.

Credit Card on File Policy: If you choose not to pay directly after the services are provided, WE ASK THAT YOU KEEP A CREDIT/DEBIT/HSA CARD ON FILE to be used for any unpaid balances. Due to the high number of deductible plans, and higher patient coinsurance benefits, this has become necessary at our organization. Please keep in mind, we will not charge your card if you do not owe anything. **Once your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization. InstaMed is registered with Visa and MasterCard and independently certified as a PCI-DSS Level One Service Provider. By signing the agreement, you understand that once the health plan has paid their portion for my care that you will receive an Explanation of Benefits (EOB). The health plan EOB will state any balance remaining to be paid by the patient. *Dermatology Specialists of Pasadena* may charge my credit card the balance due when they receive a copy of the EOB. Charges will be made ONLY after the claim has been adjudicated by your insurance and you will have received an EOB from your insurance detailing the amount billed. If the charge exceeds $250 you will receive a courtesy call or email prior to authorizing the card on file. Circumstances when your card would be charged include but are not limited to missed co-payments, deductibles and co-insurance, and non-covered services and/or denial of services. If the credit card we have on file for you changes, please notify us immediately by calling our office at (626) 817-9944.

Prescription Policy: Please call for refills during regular office hours and leave the patient's name, DOB, phone number, medication, and the pharmacy requested. Please allow 48 business hours to complete the request. Some prescriptions may be delayed due to completing a PRIOR AUTHORIZATION form set forth by the insurance companies. For oral medications, biologics, and some topical medications, the patient needs to be evaluated every 6 months. We cannot refill a prescription if the patient has not been evaluated within 12 months.

Minor Policy: All minor patients must be seen on the first visit with their Guardian/Representative.

I have read and understand the Financial & Office Policies of *Dermatology Specialists of Pasadena.*

Patient/Guardian signature: _____ Date: _____/_____/_____

Full Name: _____

Reason for Visit:_____

Past Medical History: *(please mark all that apply)*

O Anxiety
O Arthritis
O Asthma
O Atrial fibrillation
O Bone Marrow
O Transplantation
O Breast Cancer
O Colon Cancer
O COPD
O Coronary Artery Disease
O Depression
O Diabetes
O End Stage Renal Disease
O GERD
O Hearing Loss
O Hepatitis
O High Blood pressure
O HIV/AIDS
O High Cholesterol
O Thyroid Problems
O Leukemia
O Lung Cancer
O Lymphoma
O Prostate Cancer
O Radiation Treatment
O Seizures
O Stroke
O Other:_____

O NONE

Past Surgical History: *(please mark all that apply)*

O Mastectomy (Right, Left, Bilateral)
O Colectomy: Colon Cancer Resection
O Colectomy: Diverticulitis
O Colectomy: IBD
O Gallbladder Removed
O Coronary Artery Bypass
O Mechanical Valve Replacement
O Biological Valve Replacement
O Heart Transplant
O Joint Replacement, Knee (Right, Left, Bilateral)
O Joint Replacement, Hip (Right, Left, Bilateral)
O Joint Replacement within last 2 years
O Kidney Removed (Right, Left)
O Kidney Transplant
O Ovaries Removed: Endometriosis
O Ovaries Removed: Cyst
O Ovaries Removed: Ovarian Cancer
O Prostate Removed: Prostate Cancer
O Spleen Removed
O Hysterectomy: Fibroids
O Hysterectomy: Uterine Cancer
O Other: _____

O NONE

Skin Disease History: *(please mark all that apply)*

O Acne
O Actinic Keratoses
O Asthma
O Basal Cell Skin Cancer
O Blistering Sunburns
O Dry Skin
O Eczema
O Flaking or Itchy Scalp
O Hay Fever/Allergies
O Melanoma
O Poison Ivy
O Precancerous Moles
O Psoriasis
O Squamous Cell Skin Cancer
O Other: _____

O NONE

Do you wear Sunscreen? O Yes / O No

If yes, what SPF? _____

Do you tan in a tanning salon? O Yes / O No

Do you have a family history of Melanoma? O Yes / O No

If yes, which relative(s)?_____

Medications:
(Please enter all current medications)

_____
_____
_____

Allergies:
(Please enter all allergies)

_____
_____
_____

Social History:
(Please mark all that apply)

Cigarette Smoking:

O Currently Smokes
O Has smoked in the past
O Never smoked
O Former Smoker

Alcohol Use:

O EtOH- None
O EtOH- less than 1 drink per day
O EtOH -1-2 drinks per day
O EtOH -3 or more drinks per day
O Other:_____

Family Medical History
(Only first degree relatives)

_____
_____
_____

_____
_____
_____

Have you had a Pneumonia Vaccine: O Yes / O No

Date:_____

Have you had a Flu Vaccine: O Yes / O No

Date:_____

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

Symptom	YES	NO
problems with bleeding		
problems with healing		
problems with scarring		
rash		
sun sensitivity		
immunosuppression		
hay fever		
fevers or chills		
night sweats		
unintentional weight loss		
thyroid problems		
abdominal pain/diarrhea		
joint aches		
muscle weakness		
muscle aches		
headaches		
cough/shortness of breath		
wheezing		
Anxiety		
Depression		

Other Symptoms:_____

ALERTS:
(please mark ALL that apply)

O Allergy to Adhesive
O Allergy to lidocaine
O Allergy to topical antibiotics
O Artificial heart valve
O Artificial joint replacement
O Blood Thinners or Blood Clots
O Defibrillator
O MRSA
O Pacemaker
O Require antibiotics prior to surgical procedures
O Rapid heart beat with epinephrine
O Are you pregnant or currently trying?