Jennifer Baron, MD, Dermatology & Mohs
123 Di Salvo Avenue, Suite A
San Jose, CA 95128
408.418.8780 I contact@jenniferbaronmd.com

ADULT DEMOGRAPHICS

PATIENT INFORMATION			
Last Name		First Name	Middle
Social Security Number	Date of Birth	❒ Female ❒ Male	Marital Status
Language	Preferred Language for Health Care Information:		Today's Date
Mailing Street Address	City	State	Zip
Primary Contact Number ❒ Home ❒ Cell ❒ Work ( )	Second Contact Number ❒ Home ❒ Cell ❒ Work ( )	Preferred Notify Method ❒ Home ❒ Cell ❒ Work ❒ Other ( )	
Email Address			
Emergency Contact Name	Relationship to Patient	Emergency Contact Number ( )	

RESPONSIBLE PARTY'S INFORMATION (IF OTHER THAN PATIENT)			
Last Name	First Name	Middle	Relationship to Patient
Social Security Number	Date of Birth	Primary Contact Number ❒ Home ❒ Cell ❒ Work ( )	
Mailing Street Address	City	State	Zip

FAMILY AND FRIENDS ACCESS (OPTIONAL)		
I do **NOT** permit JBMD to share my protected health information with any individuals aside from myself. ❒		
Full Name	Full Name	Full Name
Relationship to Patient	Relationship to Patient	Relationship to Patient

INSURANCE INFORMATION			
Primary Insurance Carrier	Insurance Billing Address Phone ( )	Employer	
Policy Number	Group Number	Subscriber Full Name	Subsccriber Date of Birth
Secondary Insurance Carrier	Insurance Billing Address Phone ( )	Employer	
Policy Number	Group Number	Subscriber Full Name	Subscriber Date of Birth

HOW DID YOU FIND US?

❒ Primary Care or Referring Physician, PHONE# ( )
❒ Current patient ❒ Friend/Family/Co-worker ❒ Insurance Website ❒ Other Website ❒ Other

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PATIENT NAME:
DOB:

TODAY'S DATE:

CANCELLATIONS AND NO SHOWS:
Our goal is to maximize the the success of your visit and to minimize your wait time as much as possible. In order to do this, we have a standardized policy for cancellations, late patients and no shows.

❒ **Cancellation:** We require 24 hour notice of cancellation for all appointments except for surgical, procedural or Mohs appointment, for which we require 48 hour notice of cancellation. Failure to cancel within this window of time (depending on the type of visit) will result in a $150 fee for late-cancellation/missed-appointment. This fee is not payable through your insurance carrier(s).

❒ **No Show:** If you do not arrive or you are late for your scheduled appointment by 15 minutes or longer, and you did not provide the office notice within at least 24 hours, this is considered a no show.
- **First No Show –** Noted in chart
- **Second –** Warning letter mailed or emailed to patient
- **Third –** Patient is discharged from practice

MEDICATION REFILLS:
Contact your pharmacy to request medication refills. If your refill requires special assistance from our office, please call or email with your request after contacting your pharmacy first.

FINANCIAL RESPONSIBILITY:
This includes co-payments, co-insurance payments and fees for services not covered or paid by your insurance carrier under your policy. This financial responsibility also applies if your insurance carrier is not contracted with Jennifer Baron, MD, Dermatology & Mohs.

It is your responsibility to ensure that all services rendered by Jennifer Baron, MD, Dermatology & Mohs on your behalf are paid in full within thirty (30) days of the statement date. This is true for all services rendered by Jennifer Baron, MD and all other medical providers within her group.

It is important that you bring proof of insurance each time you visit the office. Failure to do so may result in your not being seen or being required to make a full payment at the time services are rendered. Please make let us know if your personal contact information (billing address, phone number, name, etc.) or your insurance carrier (primary and secondary), employer and billing information has changed since your last visit.

ASSIGNMENT AND RELEASE:
I authorize evaluation and treatment of _____(name) and agree to pay all fees for services and treatment provided by Jennifer Baron, MD and/or her designated providers. I hereby authorize my insurance benefits to be paid directly to Dr. Baron for services provided, and, I understand that I am financially responsible for any services not covered by my insurance company. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I understand that my insurance company may deny payment for any reason, including but not limited to the following: services not authorized by primary care provider or covered by my insurance policy. I acknowledge that failure to meet my financial obligations may result in a referral of my account to a collection agency.

I have read and understand all of the above financial and office policies.

Printed Name:	Date:
Signed Name or Parent/Guardian/Legal Representative:	

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PATIENT NAME:
DOB:

TODAY'S DATE:

TELECOMMUNICATION AGREEMENT:
You agree by signing below that you consent and request that Jennifer Baron, MD, may call or text you with information regarding scheduling, reminders, prescriptions, and patient care. Calls can be made to any number you provide. I understand that consent is not a condition of care. By supplying my home phone number, cell number, email address, and/or any other personal contact information, I authorize Jennifer Baron, MD, Dermatology & Mohs to employ a third-party automated outreach and messaging system to use my personal contact information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue skin exam in case of skin cancer history, balances due, lab results, or any other healthcare related function. I consent to allowing detailed messages being left on my voice mail, answering system, or with another authorized individual, if I am unavailable at the number provided by me.

I have read and understand the above.

Printed Name:	Date:
Signed Name or Parent/Guardian:	

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PARTICIPATION ACKNOWLEDGEMENT:
I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding Jennifer Baron, MD, Dermatology & Mohs participation and compliance with HIPAA, or, I previously received this information and decline another copy.

SUMMARY NOTICE OF PRIVACY PRACTICES:
Please read brief summary below. At your request, we will provide you with the full Notice of Privacy Practices as practiced in compliance with HIPAA, or, you can download it from our website: jenniferbaronmd.com.

PLEDGE TO PROTECT YOUR PRIVACY: The practice of Jennifer Baron, MD is committed to the mandatory protection of your medical and personal information. In order to address your medical needs, we may need to provide your medical records to other healthcare providers involved in your care. Your information is provided only in the extent necessary to collect payments for services, conduct business operation, and comply with laws that govern healthcare. We do not use or disclose your information for any other purpose without your explicit permission.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU: You may make the following requests to: 1) obtain a copy of your medical records with certain limitations, 2) make an amendment or addendum to your medical records, 3) restrict certain uses and disclosures of your medical information, 4) determine when and where to contact you, and 5) obtain a copy of the full version of this notice.

WE RESERVE THE RIGHT TO AMMEND AND UPDATE OUR PRIVACY PRACTICES ACCORDING TO HIPAA GUIDELINES.

I have read and understand the above.

Printed Name:	Date:
Signed Name or Parent/Guardian:	

Jennifer Baron, M.D.

DERMATOLOGY AND MOHS SURGERY

As part of our medical clinic re-opening, we are going to all reasonable and recommended measures to ensure the safety of all of our patients and staff. While there are no guarantees, we are personally invested in making your visit as stress-free as possible. Safety comes first!

PATIENT: _____DOB: _____

Please answer all to the best of your knowledge:	Yes	No	Details
In the last 3 weeks, have you or someone at home had any of these symptoms in the last 3 weeks: sore throat, cough, chills or fever, body aches, loss of smell or taste, shortness of breath?	☐	☐	
Have you or someone at home been: tested for COVID-19, been advised to be tested and / or been advised to self-quarantine?	☐	☐	
In the last month, have you or someone at home visited a: hospital, nursing home, long-term care, or other health clinic?	☐	☐	
In the last month, have you or someone at home traveled: outside the US, within the US, or on a cruise ship?	☐	☐	
Are you or someone at home an actively working healthcare provider or emergency responder?	☐	☐	
Have you or someone at home provided in-person care for someone who is in quarantine or has tested positive for COVID-19?	☐	☐	
Do you have any reason to believe that you or someone at home may have been exposed to or has become infected?	☐	☐	

_____/ _____ *(initials / date)*

Thank you for participating in this pre-visit safety process. The completed questionnaire must be received via email, fax, or mail prior to your in-person appointment.

Please follow the Centers for Disease Control guidelines as well as our office protocol that are required when entering. We must make it a priority to keep our office a safe a place for all.

If there is reason to delay treatment due to safety concerns, online, phone and video consultation with our medical professionals, Dr. Baron and Alyssa Westerfield, NP, is available to help you Monday – Friday.

Aloha, and welcome back.

Jennifer Baron, MD _____/ _____ *(date)*

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