 Phone: 805.770.8400

(\*PLEASE PRINT LEGIBLY) Fax: 805.770.8402

**PATIENT INFORMATION**

Patient Name (First & Last):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: (circle) M / F

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number:\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_ Date of Birth:\_\_\_/\_\_\_/\_\_\_\_ Marital Status: (circle) S M D W

Phone Number: (\*PLEASE CIRCLE PREFERRED IF MORE THAN ONE\*) Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are we able to leave a message with private information on the number(s) provided? \_\_\_\_\_\_\_\_\_\_

Who to notify in case of an emergency? Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_

Primary Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race: (circle) American Indian or Alaska Native / Black or African American / Native Hawaiian / Other Pacific Islander / Asian / White / Other Race / Prohibited by State Law/ Declined to State

Ethnic Group: (circle) Hispanic or Latino / *Not* Hispanic or Latino / Prohibited by State Law / Declined to State / Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYMENT INFORMATION**

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle if Applicable: Full Time Student / Part Time Student / Retired

**INSURANCE INFORMATION**

(Fill this section out If card is not present *or* you are not the responsible party)

Primary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party’s Name (Primary):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_ / \_\_\_ / \_\_\_\_\_

Responsible Party’s Name (Secondary):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_ / \_\_\_ / \_\_\_\_\_

Patient’s relationship to Insured: (circle) Spouse / Child / Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRAL INFORMATION**

How were you referred to our practice? (circle): Friend / Physician / Website / Former Patient

If Physician Referral, Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**PAST MEDICAL HISTORY**

Ongoing Medical Conditions (please list all): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKIN DISEASE HISTORY**

(Please circle all that apply)

|  |  |
| --- | --- |
|  |  |
| Squamous Cell Carcinoma | Psoriasis |
| Basal Cell Carcinoma | Eczema |
| Melanoma | Acne |

Family History of Melanoma: Y / N Family Member(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT MEDICATIONS**

Please list all prescription and over the counter medications including doses, or attach list

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DRUG ALLERGIES/INTOLERANCE**

Please list all medications AND reactions experienced (ex. Hives, Throat Swelling, Nausea, etc.)

Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

|  |  |
| --- | --- |
| **Smoking Status:*** Every day Smoker
* Some Day Smoker
* Former Smoker
* Never
 | **Alcohol Use:*** None
* Less than 1 drink per day
* 1-2 drinks per day
* 3+ drinks per day
 |



**FOR AGES 65 AND OLDER**

**VACCINATION**

**Have you received your-**

Pneumonia Vaccine? Yes No ( Please Circle )

Flu Shot? Yes No ( Please Circle )

Shingles (Zoster) Vaccine? Yes No ( Please Circle )

**ADVANCED CARE**

Do you have a health care proxy in the event you are unable to make your own medical decisions? (Circle one) Yes / No

If Yes,

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a living will? (Circle one) Yes / No

Which statement best reflects your wishes on advanced care recommendations?

* Do not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life
* Do not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life
* Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made



**PATIENT REGISTRATION FORM**

**DISCLOSURES & CONSENTS**

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorize direct payment of my insurance benefits to the physician/practice individually for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Lux Dermatology is unable to collect from my insurance carrier for whatever reason.

**AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:**

I hereby authorize Lux Dermatology to release any of my medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Our office will not release or discuss a patient’s medical chart, previous visits, nor results with anyone other than the patient unless an ‘Opportunity to Object’ form is completed. You may request an ‘Opportunity to Object’ form at our front desk, in person, or request a copy to be mailed to your address.

**LAB/X-RAY/DIAGNOSTIC SERVICES:**

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Our office partners with Western Diagnostic Laboratory for Dermatopathology and Pacific Diagnostic Laboratory for any blood work ordered.

**CONSENT TO TREATMENT:**

I hereby consent to evaluation, testing, and medical treatment. In addition, I give permission to have a biopsy(s), minor surgical procedures, and any subsequent treatment as deemed necessary as long as the risk and complications are discussed with me prior to the procedure. I understand that no guarantee has been made as to the results that may be obtained.

**ACKNOWLEDGEMENT:**

My signature or Patient’s representative signature below acknowledges that I have read and understand the disclosures & consents.

**Patient/Patient’s Representative Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**E-PRESCRIBING CONSENT FORM**

E-Prescribing is defined as a physician’s ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors, and enhances convenience for the patient while maximizing patient safety. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program.

These standards include:

* Formulary and benefit transactions- Gives the prescriber information about which drugs are covered by the patient’s drug benefit plan.
* Medication history transactions- Provides the physician with information about medications the patient is already taking to minimize adverse drug events.
* Fill status notification- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient’s prescription needs to be refilled, has been picked up, not picked up, or partially filled.

**By signing this consent form, you are agreeing that Lux Dermatology can electronically transmit your prescription directly to your pharmacy.**

E-Prescribing is an optional service and you may choose to decline. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and/or third party benefit payers (i.e. your insurance company) for treatment purposes only. Understanding all of the above, I hereby provide informed consent to Lux Dermatology to enroll me in the E-Prescribe program.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Patient’s Representative Date

**If you choose to participate in E-Prescribing, please list your preferred pharmacy below and fill in as much information as you can about said pharmacy:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Pharmacy Name Location (City and Street Name Phone Number Fax**

 **If more than one)**

**If your physician prescribes any medications, and you do not supply a pharmacy, you will receive a hand copy of said prescription.**

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**PATIENT FINANCIAL POLICY**

To reduce confusion and misunderstanding between our patients and our practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with a member of our office and we will seek a solution or answer from our billing department. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

For patients with Health Insurance (accepted by our office), the only payments due at the time of service are **co-payments** that are decided by your insurance company in advance (please note dermatology is a *Specialty* and *Specialist* co-payments are often more than a co-payment for visits with your Primary Care Provider.) Our office accepts cash, credit card, and checks.

For non-insured/self-pay patients or patients whose insurance our office does not accept, we offer a $125.00 consult visit. All follow up self-pay visits will also all be $125.00 unless a surgical procedure is scheduled in which case the price is discussed prior to the procedure, and when the patient is having sutures removed from a procedure performed in our office, in which case that visit is included in the initial price of the procedure previously discussed. The $125.00 charge covers any counseling, treatment, and evaluation done in the visit on that day of service. It does not cover medications prescribed, lab services provided outside of our office, or surgical procedures. If you have any questions as to what qualifies as any of the above, please discuss them with a member of our office staff prior to payment. **A self-pay visit must be paid in full at the time of service**, we do not offer installment plans or partial payments.

If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. In the event that your health plan determines a service to be “not covered”, you will be responsible for that charge. We will bill your health plan for all services provided. Any balance due is your responsibility and is due upon receipt of a statement from our office. **It is your responsibility as the patient to know if our physician is in network with your health plan.** If your insurance requires a referral, it is your responsibility to provide the referral to our office prior to seeing the physician.

If you have Medicare PART B only you are responsible for your Medicare deductible and your 20% of the charges from the services provided from our office.

If you have lab work performed, you will receive a separate bill from the lab offices that prep and provide lab results. Our office uses Western Diagnostic Services Laboratory for Dermatopathology (i.e. biopsies) and Pacific Diagnostic Laboratory for blood test orders. If your Health Plan has specific laboratories that are in network with your insurance, please notify us so we may instead send the tests to the preferred lab.

**I have read and understand the above policies. By signing, I am agreeing to Lux Dermatology’s Financial Policies.**

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

****

**ACKNOWLEDGEMENT OF RECEIPT OF THE**

**NOTICE OF PRIVACY PRACTICES**

**By signing below**, I hereby acknowledge that I have received from Lux Dermatology a copy of their Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how Lux Dermatology may use and/or disclose my personal health information both with and without my authorization. I further understand that I may contact the office manager if I have any questions regarding the contents of this Notice of Privacy Practices.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

You may decline to accept Lux Dermatology’s Notice of Privacy Practices with the knowledge that although a copy of the Notice of Privacy Practices was offered, you have declined and will not dispute that the knowledge within the Notice of Privacy Practices was not made aware or offered to you. You have the right to request the Notice of Privacy Practices at any time should you decide to obtain a copy. We will be happy to mail or email the Notice to you, should you not be able to pick it up at our office.

**I understand the above statement, and I am declining a copy of Lux Dermatology’s Notice of Privacy Practices.**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**