Patient Demographics

TODAY'S DATE ___ ___ / ___ ___ / ___ ___ ___ ___ (MM / DD / YYYY)

FIRST NAME (LEGAL NAME) | LAST NAME | MI ☐ N/A

GENDER AT BIRTH ☐ Female ☐ Male

STREET ADDRESS

BIRTH DATE ___ ___ / ___ ___ / ___ ___ ___ ___ (MM / DD / YYYY)

CITY | STATE | ZIP CODE

HOME PHONE ☐ N/A ( ) -

CELL PHONE ☐ N/A ( ) -

WORK PHONE ☐ N/A ( ) -

EMAIL ADDRESS:

☐ I would like to receive updates from Therapeutics Clinical Research.

Preferred contact method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ E-mail ☐ Other _____

☐ Messages may be left on voice mail or answering machine

Websites used regularly (check all that apply): ☐ Facebook ☐ Craigslist ☐ Google ☐ N/A ☐ Other _____

Employment information

OCCUPATION ☐ N/A

EMPLOYER:

☐ N/A - ☐ Student ☐ Retired ☐ Other:

Emergency Contact Information

EMERGENCY CONTACT NAME | RELATIONSHIP

PHONE NUMBER ☐ Work or ☐ Home ( ) -

CELL PHONE ☐ N/A ( ) -

Ethnicity (PLEASE CHECK ONE)

☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (PLEASE CHECK AT LEAST ONE, OR MORE IF APPLICABLE)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Study History

Have you ever been in a research study before?

☐ No ☐ Yes

Date of completion: ___ ___ / ___ ___ ___ ___ (MM / YYYY)

Are you currently participating in any study?

☐ No ☐ Yes

May we contact you for future studies?

☐ No ☐ Yes

Are you interested in participating in a study?

☐ No ☐ Yes

- FOR OFFICE USE ONLY –

☐ Phone# Check ☐ Photo I.D. Check

PATIENT SIGNATURE: | DATE:

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CLINICAL RESEARCH

Patient Medical History	PATIENT NAME: _____	TODAY'S DATE __ __ / __ __ / __ __ __ __ (MM DD YYYY)

FEMALES ONLY – PLEASE COMPLETE ♀

Menstrual Status

☐ have never menstruated
☐ menstruating - last menstrual period start date: __ __ (MM) / __ __ (DD) / __ __ __ __ (YYYY)
☐ postmenopausal – date of last menstrual period: __ __ (MM) / __ __ __ __ (YYYY)
☐ hysterectomy – Year of surgery: __ __ (MM) / __ __ __ __ (YYYY)

Your Birth Control *(please check all that apply)*

☐ abstinent/not sexually active ☐ IUD ☐ diaphragm/cervical cap ☐ tubal ligation
☐ birth control pills – name/brand: _____
Start Date: __ __ (MM) / __ __ __ __ (YYYY)
☐ Depo-Provera – Last injection: __ __ (MM) / __ __ __ __ (YYYY)
☐ postmenopausal
☐ other, specify: _____:

Your Partner's Birth Control *(please check all that apply)*

☐ condom ☐ spermicide ☐ vasectomy ☐ other, specify: _____

- OR -

MALES ONLY – PLEASE COMPLETE ♂

Your Birth Control *(please check all that apply)*

☐ abstinent/not sexually active ☐ condom ☐ spermicide ☐ vasectomy
☐ other, specify:_____

Your Partner's Birth Control *(please check all that apply)*

☐ birth control pill ☐ diaphragm/cervical cap ☐ IUD ☐ tubal ligation ☐ hysterectomy
☐ postmenopausal ☐ other, specify: _____

Dermatology History

Do you have, or have you had, any of the following: (please check all that apply) ☐ None

☐ Acne
☐ Eczema *(atopic dermatitis)*
☐ Excessive sweating
☐ Hair Loss
☐ Nail Fungus
☐ Rosacea
☐ Pre-cancers *(actinic keratosis)*
☐ Psoriasis
☐ Seborrheic Keratosis
☐ Skin Cancer
  ☐ Basal Cell
  ☐ Squamous Cell
  ☐ Melanoma
☐ Sun Damage
☐ Other, specify in comments

Comments: _____

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Patient Name: _____

General Health History

Do you have, or have you had, any of the following: (please check all that apply)

☐ None

Allergies
- ☐ Allergy, environmental/ seasonal
- ☐ Allergy to medication
- ☐ Anaphylaxis

Blood
- ☐ Anemia
- ☐ Blood transfusion

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems

Infection
- ☐ AIDS/HIV
- ☐ Hepatitis, type: _____
- ☐ Herpes
- ☐ Shingles
- ☐ Tuberculosis

Lung/Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD

Neuro/Head
- ☐ Epilepsy or seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Insomnia
- ☐ Stroke

Cardiovascular/Heart
- ☐ Arrhythmia
- ☐ Artificial Heart Valves
- ☐ Cardiovascular/Heart Disease
- ☐ Heart attack
- ☐ Heart stents
- ☐ High blood pressure
- ☐ High cholesterol

Joints
- ☐ Arthritis, type: _____
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ Gout

GI
- ☐ Gastrointestinal disease
- ☐ GERD/reflux

Mental Health
- ☐ Depression
- ☐ Psychiatric illness (other than depression)
- ☐ Chemical dependence/ addiction

Other
- ☐ Autoimmune disease
- ☐ Cancer (other than skin)
- ☐ Chemotherapy/Radiation
- ☐ Cold sores/fever blisters
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Surgery(ies)

☐ Other, specify in comments

Comments: _____

_____

Substance Use

Tobacco Use
- ☐ Never used
- ☐ Current use - ☐ Regular use ☐ Social use
- ☐ Prior use - Quit date: _____ / _____ (mo / year)

Cannabis Use
- ☐ Never used
- ☐ Current use - ☐ Regular use ☐ Social use
- ☐ Prior use - Quit date: _____ / _____ (mo / year)

Alcohol Use
- ☐ Never used
- ☐ Current use - # of drinks/week: _____
- ☐ Prior use - Quit date: _____ / _____ (mo / year)

Other Drug Use
- ☐ Never used
- ☐ Current use - ☐ Regular use ☐ Social use
- ☐ Prior use - Quit date: _____ / _____ (mo / year)

Cosmetic Treatment History

Do you have, or have you had, any of the following: (please check all that apply)

☐ None

- ☐ Botox - Location: _____ Date: _____
- ☐ Dermal fillers (ie. collagen, Restylane, Juvederm) Date: _____
- ☐ Cosmetic surgery (ie. eye lift, breast augment.) Date: _____
- ☐ Chemical peel Date: _____
- ☐ Laser/Light treatments Date: _____
- ☐ Other: _____ Date: _____

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Patient Name: _____

Medication List (please list all of your current medications and supplements) ☐ None		
	Medications and Supplements	**Reason For Taking**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Physician Contact

Do you have a Primary Care physician? ☐ Yes ☐ No

If yes, please provide the contact information below:

PHYSICIAN'S NAME		TELEPHONE NUMBER	
		( ) -	
STREET ADDRESS	CITY	STATE	ZIP CODE

Patient Signature (or Parent / Legal Guardian's Signature if patient is a minor)

_____

Patient Printed Name

_____ _____

Patient Signature *(or Parent/Legal Guardian Signature)* Date

THERAPEUTICS
CLINICAL RESEARCH

NOTICE OF PRIVACY PRACTICES

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU GENERATED AT THERAPEUTICS CLINICAL RESEARCH MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information"or"PHI" for short. It includes information that can be used to identify you. PHI includes information that we have created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice in the waiting room. You can also request a copy of this notice from the contact person listed in Section VI below at any time.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization.

We may use and disclose your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, we may disclose PHI to a pharmacy to fill a prescription, or to a laboratory to order a blood test.

2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing service and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. For example we may disclose your demographic information to a dermatopathology lab for payment of their services.

3. **For health care operations.** We may disclose your PHI, as necessary, to operate this facility and provide quality care. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4. **When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5. **For public health activities.** For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6. **For health oversight activities.** For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7. **To coroners, funeral directors, and for organ donation.** We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.

8. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct medical research, although currently we have no relationships with outside organizations to which this would apply.

9. **To avoid harm.** In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10. **For specific government functions.** We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

12. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if you would rather we contact you at an alternative telephone number or address.

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Pat. . Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***** YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT*****

I, _____, have been given the opportunity to read a copy of this office's Notice of Privacy Practices. I also understand that I have the right to request a copy of the Notice of Privacy Practice for my records.

DATE: _____ SIGNATURE: _____

RELEASE OF INFORMATION

In the event that Therapeutics Clinical Research is unable to reach me by phone, I authorize the release of information regarding appointments, surgery times or pathology/lab results to:

_____ I do not authorize release of information to anyone except me personally
_____ I authorize release of information regarding appointments, surgery times and pathology/lab results to:

Name: _____ Relationship: _____ Phone#: _____

BILLING AND INSURANCE

Responsible Party	Home Phone	
Address, City, State, Zip	Employer	Work Phone
Relationship of Patient to Responsible Party: Self Spouse Dependent		
Primary Insurance	Cardholder	Group and/or ID Number
Secondary Insurance	Cardholder	Group and/or ID Number

AUTHORIZATIONS

Authorization to Release Information: I authorize the release of any information necessary to process my insurance. I also authorize the release of any information acquired in the course of my examination or treatment to any other physician(s) involved in my case.

Authorization to Pay Benefits: I authorize my insurance company to pay Therapeutics Clinical Research directly for all surgical and/or medical benefits.

Insurance Authorization: I understand this is a lifetime signature authorization.

DATE: _____ SIGNATURE: _____

THERAPEUTICS
CLINICAL RESEARCH

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Please initial each of the following numbered items regardless of coverage/payment options (i.e. Commercial insurance, Cash Pay, etc.)

1._____ If we participate with the insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both primary and secondary insurance plans.

2._____ You will be responsible at the time of service for the payment of items such as: annual deductibles, co-pays, charges for non-covered procedures or cosmetic services.

3._____ In the event that a charge is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier. Please be advised that anything not covered by insurance is separate from your office co-pay and is subject to your deductible. When possible, we will attempt to contact your insurance to verify your benefits, but in the event we are unable to reach them, you will be responsible for your co-pay as well as payment for any procedures performed.

4._____ We are a Medicare participating provider therefore we will bill Medicare directly. You will be responsible for deductibles or co-pays or charges for non- covered or cosmetic services. You will be asked to sign an Advance Beneficiary Notice in the event that a service is provided that is not covered by Medicare.

5._____ If you do not have health insurance, payment is expected in full at the time of service.

6._____ The patient is ultimately responsible for knowing their covered insurance plan and deductible for out of pocket expenses.

7._____ Accounts more than 90 days past their due date may be sent to collections.

8._____ We kindly request that you give us 24 hours advance notice if you are unable to keep your appointment. Failure to provide notification to our office 24 hours in advance will result in a $35.00 missed appointment fee. This fee is not covered by your insurance plan and will be billed to you directly.

9._____ Co-pays are due at the time of visit. If you do not have the co-pay we will reschedule your appointment to another day.

If you have any questions, please do not hesitate to ask our clinic staff. We are here to assist you in any way possible. Your signature below signifies that you understand and agree to our financial policy and your responsibility regarding charges incurred in this office.

Please read this entire notice carefully. Ask us to explain anything you do not understand. Even if you elect to Self-Pay, all of the financial policy must be initialed in the event you decide to change from Self-Pay to Commercial Insurance at a certain point during your care.

_____

Patient Name (Print)

_____ _____

Patient Signature (*or if minor:* Guardian Signature) **Date**

Form 107 9025 Balboa Avenue, Suite 105 • San Diego, CA 92123 • 858.571.6800 FAX: 858.571.6801
info@therapeuticsresearch.com