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 newsletter updates from Therapeutics.

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

☐ Messages may be left on voice mail or answering machine

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)	**Race** (PLEASE CHECK AT LEAST ONE, OR MORE IF APPLICABLE)
☐ Hispanic or Latino ☐ Not Hispanic or Latino	☐ 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
Are you interested in participating in a study? ☐ No ☐ Yes	- FOR OFFICE USE ONLY – ☐ Phone# Check ☐ Photo I.D. Check

PATIENT SIGNATURE:	DATE:

THERAPEUTICS
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: ____
____

THERAPEUTICS CLINICAL RESEARCH

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:________________________________

THERAPEUTICS
CLINICAL RESEARCH

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.

B. Uses and Disclosures Where You to Have the Opportunity to Object:

1. **Disclosures to family, friends, or others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.
2. **Services Paid in Full "Out of Pocket."** If you have paid for services "out of pocket," in full, and you request in writing that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure

C. All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003.

We will respond within 60 days of receiving your written request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

G. The Right to Be Notified of a Breach of PHI. You have the right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Privacy Officer, 9025 Balboa Ave, Suite 105, San Diego, CA 92123. Phone: 858-571-6800; Fax: 858-571-6801.
E-mail: bparker@therapeuticsresearch.com.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice is effective April 14, 2003.

THERAPEUTICS
CLINICAL RESEARCH

Patient 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#: ____________________

_____ I give permission to leave a message on my answering machine.
_____ I give permission to contact me at the email address above.

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: ____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice Privacy Practice, but acknowledgement could not be obtained due to the following:

________ Individual refused to sign

________ Communication barriers prohibited obtaining the acknowledgement

________ An emergency situation prevented us from obtaining acknowledgement

Other: ____

____ ____________________
Practice Representative Date

THERAPEUTICS
CLINICAL RESEARCH

Patient Name: ______________________

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.

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.___________ In the event we receive a returned check due to insufficient funds, a fee of $ 25.00 will be charged to your account and payment is due upon receipt of your statement.

7.___________ If you purchase skin-care products or supplies from our office, please understand that these products/supplies are non-refundable items. In the event the product/supply is defective, we will gladly replace the item(s).

8.___________ We kindly request that you give us 24 hours advance notice if you are unable to keep your appointment. Failure to give 24 hours advance notice will result in a $35.00 missed appointment fee. This fee is not covered by your insurance plan.

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. We are here to assist you in any way possible. Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Before you make a decision about your options, you should read this entire notice carefully. Ask us to explain anything you do not understand.

Option 1. _________ Yes, I want to receive treatment or services.

Option 2. _________ No, I have decided not to receive treatment or services.

____ ______________________

Patient/Guardian Signature **Date**

V 1.1 6/9/14

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