Dermatology Institute & Skin Care Center
2001 Santa Monica Blvd Suite 1160W | Santa Monica CA 90404
o 310-829-4104 | f 310-829-4150 | e info@discc.com

PATIENT INFORMATION

Name:_____/_____/_____
Last Middle First

Address:_____Apt:_____

City_____State_____Zip_____

Date of Birth:_____ Cell Phone:(_____)_____Email:_____

May we discuss your condition with anyone else? □ No □Yes Name: _____

How were you referred to our office?

□ Doctor: _____ □ Insurance □ Friend/ Family □ Yelp □ Google

INSURANCE INFORMATION

A copy of the insurance cards has been provided YES NO

Subscriber: _____ Subscriber Date Of Birth:_____ Relationship to Subscriber: _____

EMERGENCY CONTACT

In case of an emergency, we will contact this person.

Name: _____Relationship:_____Phone:_____

OFFICE POLICIES

Insurance Plans. Insurance cards are expected to be brought to every visit. If your insurance changes, it is your responsibility to notify us as soon as possible with your updated cards. If the insurance card/ plan you present is incorrect or invalid, you will be responsible for payment of the visit. According to insurance plans, you are responsible for all copays, deductibles and coinsurances. Copayments are due at time of service. Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit. **INITIALS_____**

Missed Appointments. Missed appointments will result in a $75 cancellation fee. Please cancel at least 24 hours in advance of your appointment time. **INITIALS_____**

Nonpayment. If your account is over 90 days past due and if the balance remains unpaid, we may refer your account to a collection agency. **INITIALS_____**

Prescription Refills. All medications will be sent to the Specialty Pharmacies of our choosing to ensure no delay in medication due to prior authorizations. We require 48 hours notice, during regular business hours.**INITIALS_____**

HIPAA & NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. I understand that **Dermatology Institute & Skin Care Center** may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization. **Dermatology Institute & Skin Care Center** has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, **Dermatology Institute & Skin Care Center** will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such a copy of the *Notice of Privacy Practices*. My signature means that I agree to allow the **Dermatology Institute & Skin Care Center** to use and disclose my protected health

SIGNATURE OF PATIENT or GUARDIAN:_____**Date:**_____