4520 Executive Drive, Ste 325
San Diego, CA 92121
(P) 858-452-1430
(F) 858-452-0651

9850 Genesee Avenue, Suite 850
La Jolla CA, 92037
(P) 858-657-0267
(F) 858-657-9485

890 Eastlake Parkway, Ste. 202
Chula Vista CA, 91914
(P) 619-754-6869
(F) 619-754-6870

COASTAL
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Date of Appointment: _____

Patient's Legal Name: _____

Email Address: _____(Your email will enable your **patient portal** access to your medical records)

Address: _____

City: _____ State: _____ Zip: _____

Home#: (_____) _____ Mobile#: (____) _____ Work#: (_____) _____

Date of Birth: ____/____/____ Age: _____ Sex: _____ SS#: _____-_____-_____

Patient's Occupation: _____Marital Status:☐**Single**☐**Married**☐**Divorced** ☐**Widowed** ☐**Legally Separated**

Emergency Contact: _____ Relationship: _____ Phone# :(_____) _____

Name of Spouse: _____

Is there a **pharmacy** that you use regularly? If so, please list the name of the pharmacy and the street where it is located. We have most San Diego County pharmacies on file.

Pharmacy Name: _____

Address/Street Name/Cross Street: _____ Phone Number: _____

Referring Physician/Primary Care Physician _____ Phone Number:_____

INSURANCE #1 POLICY HOLDER ☐ self ☐ spouse ☐ parent ☐ other

Insurance Policy Holder's Name (*if not patient*): _____
Relationship to Patient:_____ **Date of Birth:** ____/____/____ **SS#:**_____-_____-_____
Employer: _____

If you have a secondary policy, please fill out the information below:

INSURANCE #2 POLICY HOLDER ☐ self ☐ spouse ☐ parent ☐ other

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COASTAL MEDICAL & COSMETIC DERMATOLOGY

Insurance Policy Holder's Name (*if not patient*): _____

Relationship to Patient:_____ **Date of Birth:** ____/____/____ **SS#:**_____-_____-_____

Employer: _____

Continued on back side

Name:_____

Allergies:_____ **Height:** _____ **Weight:** _____

Current Medications and Dosages: _____

_____

Major Medical Illnesses/Surgeries: _____

Pacemaker: **Yes** ⬭ **NO** ⬭ **If yes, when placed?**_____

Reason for today's visit: _____

How did you find us? ⬭ **My insurance company** ⬭ **Yelp** ⬭ **Google** ⬭ **Facebook** ⬭ **Instagram**
⬭ **My family/ friend whose name is**_____

⬭ **My primary doctor whose name is**_____ ⬭ **Other** _____

⬭ **Another Doctor whose name is** _____

Hobbies _____

Past Medical/Family History: Check if you personally have or anyone in your family has:

Family/Parent History	Please Indicate	If deceased, reason
Father	O Alive O Deceased	
Mother	O Alive O Deceased	

Personal/Family History	Self	Relative/Relation	Month/Year
Skin Cancer			
Malignant Melanoma			
Eczema			
Other Cancer			
Psoriasis			

(PLEASE CIRCLE)

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Race: Asian/Caucasian/Native American/African American/Black/Pacific Islander /Hispanic/Other: _____

Ethnicity: Hispanic/Non Hispanic **Language:** _____ Decline ·

Continued on back side

Contacting You Regarding Laboratory Information

Our office wants to make sure that your privacy is always protected. From time to time we may need to contact you regarding laboratory results. By checking the box below you will give us permission to leave a detailed message on your voice message system. Otherwise, we will only give detailed information when we speak with you personally by phone or in person to protect your privacy.

☐ By checking this box I give permission to Coastal Medical & Cosmetic Dermatology and his staff to leave a detailed voice message system regarding laboratory results or pathology results.

By signing this form confirms you have read the details in this form and agree.

Mark each that is ok to leave a Detailed Message: ☐HOME ☐CELL

X **Patient / Responsible Party Signature** _____ **Date:** _____

Do you give permission for another person to access your medical records, financial records, and lab/pathology results?

□ Yes □ No

Name (if yes): : _____ Relationship: _____Phone# :(_____) _____

Name (if yes): : _____ Relationship: _____Phone# :(_____) _____

X **Patient / Responsible Party Signature** _____ **Date:** _____

Advance Beneficiary Notice

You want the items or services that may not be paid for by Medicare. Your provider or supplier may ask you to pay for them now, but you also want them to submit a claim to Medicare for the items or services. If Medicare denies payment, you're responsible for paying, but, since a claim was submitted, you can appeal to Medicare.

X

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Patient / Responsible Party Signature _____ **Date:** _____

Continued on back side

Coastal Medical and Cosmetic Dermatology Payment Policy

(ADVANCED BENEFICIARY NOTICE)

PLEASE READ CAREFULLY AN THOROUGHLY

● I understand that regardless of my insurance coverage, I am financially responsible for all medical services received.

● **Co-payments:** Co-payments are required on the day of your appointment.

● **Deductibles:** If you have not met your deductible for your plan year, you will be required to pay it on the day of your appointment. Please keep in mind that any medical procedure performed does have an associated fee.

● **Prior Authorizations:** If your insurance requires prior authorizations for services, and is not obtained prior to your appointment or procedure, your are fully responsible for all charges incurred.

● **O X ue Patient-due Balances:** Your payment is required within 10 days of the receipts of your patient statement. CMCD reserves the right to charge 5% interest on all patient due balances not paid within 30 days.

● **Insurance Cards:** Your insurance card is required at each visit. It is the patient's/responsible party responsibility to notify this office if your insurance plan(s) change and provide this office with a copy of the new insurance card. Alternatively, you can pay for the services on the day of your visit and bill your insurance yourself.

● **Cancelled or Missed Appointments:** There is a 24 hour cancellation requirement. You will be charged a **$75.00** "missed appointment" fee for failure to give a 24 hour cancellation notification. A charge of **$100.00** will be assessed for missing a scheduled "procedure" or failing to cancel 24 hours prior to a scheduled procedure.

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● **Know your insurance benefits**! : As a courtesy, we will bill your primary and secondary insurance companies: however you are ultimately responsible for payment of services not covered by your insurance plan.

X **Patient / Responsible Party Signature** _____ **Date:** _____

Continued on back side

HIPAA Compliance
Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

_____ _____
Patient Name **Date**

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 Coastal Medical & Cosmetic Dermatology 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 operation. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Coastal Medical and Cosmetic Dermatology 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, Coastal Medical and Cosmetic Dermatology 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 copy of the *Notice Privacy Practices*. My signature means that I agree to allow Coastal Medical and Cosmetic Dermatology to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Coastal Medical and Cosmetic Dermatology has take action relying on this consent.

X _____ X _____

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COASTAL MEDICAL & COSMETIC DERMATOLOGY

Signature Date

_____ _____

Relationship (if minor) Date

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our '*Notice*' at any time by contacting: Coastal Medical & Cosmetic Dermatology, 9850 Genesee Ave. Suite 850, La Jolla, CA 92037, Phone: 858-657-0267, Fax: 858-657-9485

Continued on back side

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical service rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinic, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnancy mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee form the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any exiting court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and if (applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligent, and the arbitration shall be governed pursuant to Code of Civil Procedure 1280-1295 and the Federal Arbitration Act (9 U.S.C. 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient Intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with California Law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

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NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____
Physicians or Duly Authorized Representative Date

By:_____
Print or Stamp Name of Physician Date

X

By:_____
Patient's Signature Date:

By:_____
Print Patient's Signature