Dr. Michael R. Lerner
2881 Fourth Ave Phone: (619) 291-8292
San, Diego, CA 92103 Email: dsm2881@gmail.com

Dermatology
Surgical and Medical

The physician and staff of Dermatology Surgical and Medical value and appreciate your selection of our office for your skin care. We are committed to providing you with the best possible service. A clear understanding of our office policy is important to our professional relationship.

Insurance and Managed Care

We accept PPO insurance plans. We do not accept any HMO, MediCal, or hospital affiliated plans. Please inquire upon check-in to see if we accept your plan to avoid future billing issues. If your insurance plan requires a referral, you must have a valid referral before being seen in our office. If your visit has not been authorized you may reschedule or you can opt to become a cash-patient and be responsible for the full cost.

Appointment Canceling Policy

We kindly ask for 24 hours notice if you cannot keep your scheduled appointment so that we may fill that opening. We reserve the right to charge a $50.00 deposit if you cancel within 24 hours more than once.

If you have any questions, please feel free to inquire before signing below.

I have read and understand the above policies.

Patient signature _____ Date _____

Guarantor signature (if guarantor is not the patient)_____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, the undersigned, hereby request and give consent for medical and/or surgical treatment by Dr. Michael R. Lerner. I accept financial responsibility for the charges and allow medical insurance claims benefits for services rendered by Dr. M. Lerner to be paid on my behalf directly to Dr. M. Lerner. I also authorize Dr. M. Lerner to release to the insurer or its agency, any medical, employment, or other information pertinent to the processing of insurance claims submitted by him on my behalf. I understand that if my account with this office becomes delinquent, interest shall accrue on the delinquent balance at the maximum legal rate. If my account is referred to an attorney or service for collection, I shall also pay reasonable attorney's fees and all related expenses of the collection. I hereby consent to and authorize DSM to use and disclose any of my health information, including my medical records and prescription medical history, for purposes concerning my treatment, payment for health care provided to me or the health care operations of DSM or other treating health care provider or plan.

I have read Dermatology Surgical and Medical Notice of Privacy Practices

Signature of patient or guardian_____ Date _____

Patient Authorization Photographs

I give Dermatology Surgical and Medical permission to take clinical photographs for my medical record. I understand that the photographs remain the property of the office and will not be shared with other medical personnel unless deemed necessary for the improvement of my continued care.

Signature of patient or guardian: _____

Name: _____ Date of Birth:_____ Date: _____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Please complete patient contact information below:

Address: _____ City/State/Zip: _____

Home phone: _____ May we leave a detailed message on your answering machine? _____

Work phone: _____ May we leave a detailed message on your answering machine? _____

Cell phone: _____ May we leave a detailed message on your answering machine? _____

E-mail: _____ May we e-mail a message to you? _____

Social Security Number: _____ Occupation: _____

How did you hear about us? _____

Who is your Primary Care Physician? _____

Are you ALLERGIC or have you had ADVERSE REACIONS to any MEDICATIONS, FOODS, LATEX, OR RUBBER, or other products? Yes No If yes, please list and explain _____

_____

List ALL MEDICATIONS, PRESCRIPTIONS, and/or NON-PRESCRIPTION drugs that you take daily.

_____

_____

ANY SIGNIFICANT HEALTH PROBLEMS: _____

_____

Are you pregnant, breast-feeding, or planning a pregnancy in the near future?	Yes	No
Have you ever had a reaction to local anesthesia (Lidocaine/Epinephrine)?	Yes	No
Have you had skin reactions to band-aids, adhesive tape, antibiotic ointments or topical creams?	Yes	No

<u>Authorization to Disclose Protected Health Information to family, friends, and/or others</u>

By signing below, I have authorized Dermatology Surgical and Medical to disclose my Personal Health Information to the following family or others:

Name: _____ relationship_____ telephone # _____

Patient or guardian signature _____ Date: _____

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MACRA Patient Registration Form

In compliance with the HITCH Act to attain MACRA, we are required to obtain certain demographic & health information. This is an important part of you medical history and require for our clinical quality improvement measures. Please complete the information below.

Vaccinations & Health Information:

Have you received a Flu Vaccination in the last year?	Yes	No
Have you received a Pneumonia Vaccination in the last year?	Yes	No
What is your normal blood pressure?	_____/_____	

Tobacco Use:

_____ Never smoker

_____ Former smoker

_____ Current every day smoker

_____ Current some days smoker

If smoking; number of packs per day: _____

Date started smoking: _____

Date stopped smoking: _____