TORREY PINES DERMATOLOGY

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Initial:	
Mailing Address:	City:	State:	Zip:
Email address:	Would you like to receive emails on our current specials? ☐ Yes ☐ No		
Home Phone: ( )	Mobile Phone: ( )	Work Phone and Extension: ( )	
Patient DOB:	Age:	Sex:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Ethnicity: ☐ Hispanic / Latin ☐ Not Hispanic or Latin ☐ Decline to State	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian / Other Pacific ☐ Black or African American ☐ White ☐ Hispanic ☐ Other Race ☐ Decline to State		
Preferred Language: ☐ English ☐ Other: _____	Social Security Number:	Occupation:	
Primary Care Physician and Phone:	Referring Provider and Phone:		
How Did You Hear About Our Office?			

IN CASE OF EMERGENCY

Name of Emergency Contact Person:	Relationship to Patient	Home Phone: ( )	Cell Phone: ( )

RESPONSIBLE PARTY (GUARANTOR) *(if patient is spouse, dependent, or student)*

Guarantor's Last Name:	Guarantor's First Name:	Guarantor's Middle Name:	
Mailing Address:	City:	State:	Zip:
Guarantor's DOB:	Relationship to Patient:	Home Phone: ( )	Cell Phone: ( )

PRIMARY INSURANCE *(please present new insurance card to our office staff)*

☐ Self-Pay / No Insurance ☐ Patient is the Insured Subscriber	Policy Subscriber's Name *(if not patient):*	Policy Subscriber's DOB *(if not patient):*	
Name of Primary Insurance:	Primary Insurance Address:	Policy Subscriber's Phone: ( )	
Patient's Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:	Policy Subscriber's Social Security #:		
Subscriber Number:	Group Number:	Specialist Co-Pay: $	

SECONDARY INSURANCE *(please present new insurance card to our office staff)*

☐ Self-Pay / No Insurance ☐ Patient is the Insured Subscriber	Policy Subscriber's Name *(if not patient):*	Policy Subscriber's DOB *(if not patient)*	
Name of Secondary Insurance:	Secondary Insurance Address:	Policy Subscriber's Phone: ( )	
Patient's Relation to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:	Policy Subscriber's Social Security #:		
Subscriber Number:	Group Number:	Specialist Co-Pay: $	

PHARMACY INFORMATION

Pharmacy Name:	Pharmacy Location *(address or intersection is okay)*:	Pharmacy Phone: ( )

Please continue onto back….

Please list any medications you are currently taking:

Name	Dose	Name	Dose
1)		**4)**	
2)		**5)**	
3)		**6)**	

If you are allergic to any medications, please list below:

Name	Reaction Type	Name	Reaction Type
1)		**3)**	
2)		**4)**	

Please list any major surgeries and/or hospitalizations:

1)	Date:	**3)**	Date:
2)	Date:	**4)**	Date:

Do you have now, or have you ever had diseases or conditions of: (Please circle all that apply)

Anxiety	Colon Cancer	Hearing Loss	Leukemia
Arthritis	COPD	Hepatitis	Lung Cancer
Asthma	Coronary Artery Disease	Hypertension	Lymphoma
Atrial Fibrillation	Depression	HIV/AIDS	Prostate Cancer
Bone Marrow Transplant	Diabetes	Hypercholesterolemia	Radiation Treatment
BHP	End Stage Renal Disease	Hyperthyroidism	Seizures
Breast Cancer	GERD (Acid Reflux)	Hypothyroidism	Stroke

Do you have any of the following skin conditions? (Please circle all that apply)

Acne	Dry Skin	Melanoma	Psoriasis
Actinic Keratosis	Eczema	Poison Ivy	Squamous Cell Skin Cancer
Basal Cell Skin Cancer	Flaking or Itchy Scalp	Precancerous Moles	Other:_____
Blistering Sunburns	Hay Fever/ Allergies		

Social History:

Have you received the flu vaccine in the past year?	☐ Yes ☐ No
Have you received the pneumonia vaccine?	☐ Yes ☐ No
Do you wear sunscreen? If yes, SPF_____	☐ Yes ☐ No
Do you use tanning beds?	☐ Yes ☐ No
Do you smoke?	☐ Never ☐ Former Smoker ☐ Current Smoker
Do you drink alcohol? If yes _____ drinks per day	☐ Yes ☐ No
Do you drink caffeine? If yes _____ cups per day	☐ Yes ☐ No
Do you exercise?	☐ Never ☐ Daily ☐ Weekly

Please list any relatives that have had any of the following:

Disease	Relative	Disease	Relative
Autoimmune Disease	_____	Elevated Cholesterol	_____
Cancer	_____	Melanoma	_____
Diabetes	_____	Psoriasis	_____
Eczema	_____	Skin Cancer	_____

Financial Policy – All Patients, Including Medicare

Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments will be collected. The patient is responsible for any/all charges not paid for by their insurance company. I agree, either as an agent or as the patient, that I am obligated to pay any/all fees for the exam that may not be covered or authorized by my insurance carrier.

Financial Policy – Medicare Patients Only

I authorize any holder of medical records or other information about me to release to the Social Security Administration and Center for Medicare Services, or its intermediaries or carrier, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

No-Show & Cancellation Policy

Appointment times at Torrey Pines Dermatology are scheduled to allow us to give proper care to each individual patient's needs during the patient's visit. We value advance notice from our patients who are unable to attend their scheduled appointments in order to open appointments for patients on our waiting list. To promote efficient access to Torrey Pines Dermatology, we maintain a No Show/Cancellation policy to all our patients. We require appointments to be cancelled 24 business hours before the scheduled appointment. Cancellations must be made during our business hours of 8 a.m. and 4:30 p.m. by phone at (858) 362-8800.

In the event that an appointment is missed or cancelled with less than a 24-hour notice or no notice at all, a **$100 non-insurance charge** will be billed to the patient. If the patient is cosmetic and has a package of cosmetic treatments, **one treatment will be removed** from the package.

This policy is in effect for all patient appointments at our practice, including clinical research, and cosmetic appointments.

I understand that I will be charged a $100 fee if I do not call to cancel an appointment within 24 hours of the scheduled appointment time.

Privacy Practices (HIPAA)

Receipt of Privacy Practices: You have a right to obtain a paper copy of this notice upon request.
Contact Information: You have the right to request Torrey Pines Dermatology to communicate with you using a preferred method.

If you are over 18 years old, do we have permission to speak to a designated person about your care?
If yes, Please list any persons to whom your protected health information CAN be disclosed (e.g. spouse, parent, caregiver, etc.):

Name: _____ Relationship:_____

Name: _____ Relationship: _____

My signature below acknowledges that I have read, understood, and agreed to all the above Torrey Pines Dermatology Policies.

Please Print Patient's Name: _____

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

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DERMATOLOGY

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_____ _____

Patient Signature Date

_____

Name (Please Print)

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DERMATOLOGY

Patient Consent to Treatment & Financial Responsibility

I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize an examination by my doctor and such assistant or staff as may be assigned by the physician. I authorize Torrey Pines Dermatology to fax my records to any physician or pharmacy for the purpose of coordinating or managing my healthcare. We have contracts with many insurance companies to accept assignment of benefits for our services. In order to do this we must have a valid insurance card and a driver's license or other legal form of identification at the time of the visit or you will be charged as a private pay patient and charges for your visit will be your complete responsibility. You are responsible for knowing your insurance coverage and benefits. Insurance coverage varies from plan to plan. Torrey Pines Dermatology will not waive your financial responsibly if your insurance provider denies payment. Your co-pay and any deductible are expected at the time of service. We accept Cash, Check, Credit Card and sometimes Care Credit.

As a service to you, we will file your insurance claim. You will be billed for any amount not covered by the insurance company, including deductibles, surgical/pathology deductibles and co-insurance. Payment is due upon receipt of your statement. For cosmetic services not covered by health insurance, charges are payable on or before the day service. Photography is at times a necessary part of planning and evaluating treatment. Patient or responsible party authorize the taking of photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed. Torrey Pines Dermatology shall be entitled to recover any losses or damages it may suffer by reason of a failure of the patient and/or responsible party to pay charges when they become due, including, but not limited to, reasonable attorney fees, plus costs of enforcing this agreement. Any amounts overdue for more than thirty (30) days shall accrue interest at the rate of 1.5% per month. Balances delinquent more than 90 days are subject to collection efforts and associated reporting to collection agencies. Patient will be responsible to pay Torrey Pines Dermatology for fee's charged by assigned collection agency.

I authorize that payment of Medicare or other commercial insurance company benefits be made to Torrey Pines Dermatology for services provided.

I authorize the release of any information needed for processing of this or any related claims. I will permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand that all outside laboratory testing will be billed from the specific laboratories to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment. A copy of this authorization shall be considered as valid as the original. I acknowledge I have read this information thoroughly and understand this patient financial responsibility form.

If it becomes necessary to cancel or change your appointment, we require at least 24 hours advanced notice. This is important so that we may offer appointment time to another patient in need of seeing the doctor. If an appointment is cancelled or changed with less than 24 hours' notice, there will be a $100 cancellation fee applied to account or 50% of cosmetic service, whichever is greater. These fees will also be applied to patients account for any appointment no-show. These fees will be the responsibility of patient or party financially responsible for patient.

_____	_____	_____
Signature of Patient	Print Name	Date
_____	_____	_____
Signature of Financial Guarantor/Responsible Party	Print Name	Date

_____

Relationship of Financial Guarantor/Responsible Party

Torrey Pines Dermatology
E-mail Use Consent

I am:

_____a) An established patient of Torrey Pines Dermatology

_____b) The legal representative of an established patient.

The authorized use to communicate to this email address(es):

_____

I may want to communicate with the providers and staff of Torrey Pines Dermatology by e-mail.

I understand the risks of communication by email, in particular, the privacy risks explained in this form.

I understand that Torrey Pines Dermatology cannot guarantee the security and confidentiality of e-mail communication. The physicians, staff, and Torrey Pines Dermatology will not be responsible for messages that are not received or delivered due to technical failure or for disclosure of confidential information unless caused by intentional misconduct.

I understand that I may also communicate with Torrey Pines Dermatology by telephone or during a scheduled appointment, and that email is not a substitute for care that may be provided during an office visit. Appointments should be made to discuss any new or complex issues.

I understand that I may stop using e-mail as a means of communication upon my written request.

I understand that I may revoke this consent at any time by advising Torrey Pines Dermatology in writing. My revocation of consent will not affect my ability to obtain future health care, nor will it cause the loss of any benefits to which I am otherwise entitled.

I have read and understand this form. I have had the opportunity to ask questions, and my questions have been answered to my satisfaction. I understand and agree with the information contained in this form and give my consent for e-mail communications to and from Torrey Pines Dermatology.

Date: _____

Patient Name: _____

Patient or Legal Representative Signature: _____

Legal Representative name (if applicable) _____
(for example, parent/guardian if under 18)