

Patient Name		M <input type="checkbox"/> F <input type="checkbox"/>	Appt. Date
Home Addr.		Home # () -	
Date of Birth	Marital Status	Driver's Lic. #	
Social Sec. #	Employer	Occupation	
Empl. Addr.		Work # () -	
If patient is a minor, parent/legal guardian?		Phone # () -	
In case of emergency, notify?		Phone # () -	
Primary Care Physician		Referred by	
If you were referred by a friend, may we thank him/her? Y <input type="checkbox"/> N <input type="checkbox"/> Friend's name _____			
How did you learn about this practice? <input type="checkbox"/> Insurance <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Sacramento Magazine <input type="checkbox"/> Seminar <input type="checkbox"/> Folsom Telegraph <input type="checkbox"/> El Dorado Hills Village Life <input type="checkbox"/> Community Event <input type="checkbox"/> Other _____			

Primary Insurance Information

Ins. Carrier	Ins. Addr.		
Subscriber Name	Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> _____		
Subs. Social Sec. #	Ins. ID #	Group #	

Secondary Insurance Information

Ins. Carrier	Ins. Addr.		
Subscriber Name	Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> _____		
Subs. Social Sec. #	Ins. ID #	Group #	

By signing below, I request payment of authorized Medicare/Insurance benefits to be made on my behalf to David No, M.D., Ph.D. for any services provided. I authorize any holder of medical information about me to release to the Health Care Financing Administration/or my Insurance company, and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare-assigned cases, or Insurance companies contracted with this provider, the provider agrees to accept the charge determination of the Medicare carrier or insurance company as the full charge, and I am responsible for the deductible, co-insurance, and non-covered services. Note: All insurance companies, including Medicare, only pay for services that they determine to be "reasonable and necessary." If Medicare/Insurance company determines that a particular service is not "reasonable and necessary" under their program standards, they will deny payment for that service. *Medicare and Insurances usually do **NOT** pay for cosmetic procedures.* I have read the payment policy, and I do agree to be bound by its terms.

 Patient or Responsible Party

 Date

For MEDIGAP policy holders: I authorize MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of Medical Information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

 Patient or Responsible Party

 Date

Name	Date of Birth	Appointment Date
Primary Care Physician (PCP) <i>Name</i> <i>Address</i> <i>Phone</i>	Medications (including over the counter)	Allergies to Medications
Were you referred by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If other than your PCP, please list below. <i>Name</i> <i>Address</i> <i>Phone</i>		Do you take antibiotics before going to the dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why?
	Do you take blood thinners? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list.	

Medical History

<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure	Please list other Medical Problems.
<input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker	
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve	
<input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Disorders	
<input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease	
<input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joint/Prosthetic	
<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	
<input type="checkbox"/> Yes <input type="checkbox"/> No Asthma	
<input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever	
<input type="checkbox"/> Yes <input type="checkbox"/> No Keloids	

Family History/Social History

• Do you or any relative have? If yes, relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Melanoma <input type="checkbox"/> Yes <input type="checkbox"/> No Psoriasis <input type="checkbox"/> Yes <input type="checkbox"/> No Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No Vitiligo	Other Family Diseases	Hobbies	Occupation
		Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you drink regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No

Review of Systems

• Have you currently/recently had symptoms of...?	If yes, please describe.
Skin (Other than primary reason for visit) <input type="checkbox"/> Yes <input type="checkbox"/> No	
General Health <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	
Ears/Nose/Mouth/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart <input type="checkbox"/> Yes <input type="checkbox"/> No	
Liver <input type="checkbox"/> Yes <input type="checkbox"/> No	
Lungs <input type="checkbox"/> Yes <input type="checkbox"/> No	
Stomach/Bowel <input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidneys <input type="checkbox"/> Yes <input type="checkbox"/> No	
Headaches/Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychological <input type="checkbox"/> Yes <input type="checkbox"/> No	
Thyroid/Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood/Bleeding Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	
Females: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient Signature

Date

Physician Signature

Date

Practice Policies

Welcome to our practice. We appreciate the opportunity to meet with you to discuss skin issues and to optimize a treatment regimen. We are committed to making your visit a pleasant and comfortable one. Please take a minute to review a summary of our practice policies.

TELEPHONE CALLS

During office hours, our receptionists are instructed to handle all incoming calls. If you need to speak with the doctor, the receptionist must take your name, telephone number, and the nature of your call. This enables the doctor to have your chart available when he returns your call. After-hour dermatological emergencies should be directed to our main phone number 916.983.3373. The automated telephone system will instruct you how to reach the doctor.

INSURANCE AND PAYMENT

We recommend that you contact your insurance company regarding the need for a referral or any coverage issues for an anticipated service. If a referral is required, you must have it sent to our office **prior** to your appointment. Our Insurance Specialist will also contact your insurance company to verify your eligibility and benefits. We will bill your insurance company/Medicare if your treatment is medically necessary. To the best of our ability, we will estimate the amount of the charges for which you will be responsible (deductible, co-pay, 20%, etc.). **Payment of your portion of the charges is due at the time of service.** After your claim is processed by your insurance company/Medicare, we may need to bill you to reconcile any remaining balances. We require any balance to be paid in full within *90* days. If we overestimated your responsibility, we will promptly send you a refund.

COSMETIC SERVICES

There is an \$85 consultation fee for all cosmetic consultations. The quote for any cosmetic procedure is discretionary, and can only be determined after a physical examination by your doctor. Typically, cosmetic procedures are **not** covered by insurance policies. **For cosmetic procedures, we require payment in full at the time of service.** Larger procedures, such as laser resurfacing, will require payment in advance. For your convenience, we accept cash, check, MasterCard and Visa. Returned checks will incur a \$25 fee

CHILDREN

Children under the age of 18 will require a parent or legal guardian to be seen by the doctor. For your children's protection, children under the age of 12 are not allowed in the waiting room without adult supervision. Children under the age of 12 are not allowed in the examination room during laser treatment unless they are a scheduled patient.

PRIVACY AND MEDICAL RECORD

Please refer to the Notice of Privacy Policies for further details regarding your privacy rights and rights to your medical record. Copies of your medical record can be obtained with written consent. There is an administrative fee of \$20 per copy.

Signature

Print Name

Date

HIPAA Acknowledgement Form

As required as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- By signing below, you are acknowledging receipt of this practice's "Notice of Privacy Practices".
- Because we are involved with your dermatological care, we may need to contact you regarding your appointments, care plan, and/or test results. Please answer the following questions regarding how we will be authorized to contact you.

Yes **No**

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | May we identify ourselves as representatives of this office during our oral and written correspondence with you? |
| <input type="checkbox"/> | <input type="checkbox"/> | May we leave messages on your home answering machine/voice mail identifying this practice? |
| <input type="checkbox"/> | <input type="checkbox"/> | May we leave messages on your work answering machine/voice mail identifying this practice? |
| <input type="checkbox"/> | <input type="checkbox"/> | May we disclose any laboratory results, biopsy results, or other care issues to a family or household member? If so, with whom may we disclose this information? |

Name(s) and Relation(s)

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | May we leave messages on your home answering machine/voice mail detailing any laboratory results, biopsy results, or other care issues? |
|--------------------------|--------------------------|--|

Patient Signature

Date

(If not the patient, please note relationship to patient. _____)