PATIENT REGISTRATION

Name: _____ ☐ Jr. ☐ Sr.
Last First Middle

Prefer to be called: _____ Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss

Address: _____
Street # Street Nane Apt. #

_____
City state Zip

Home Phone: _____ Work Phone: _____

SS#: _____ Drivers Licence #: _____

Dateof Birth: _____/_____/_____ Age: _____ Sex: _____ Marital Status: _____

Employer : _____
name Address Phone

Spouse: _____ Spouse's date of birth: _____

Who referred you?: _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: _____
Last First M.I.

Address: _____
City State Zip

Home Phone: _____ Work Phone: _____ SS#: _____

Date of Birth: _____/_____/_____ Sex: _____

INSURANCE INFORMATION (Please present insurance cards at the time of check in.)

Primary Insurance Name _____	**Secondary** Insurance Name _____
Ins. Address _____	Ins. Address _____
Name of insured _____	Name of insured _____
Insured's ID# _____	Insured's ID# _____
Group # _____	Group # _____
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
Employer Phone _____	Employer Phone _____
Relationship of patient to insured _____	Relationship of patient to insured _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff Is trained to consistently inform you of the financial payment policies of the office. 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 and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature: _____ Date: _____

PATIENT REGISTRATION
(Continued)

Name: _____ Date: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: _____ Date: _____

Other family members that are patients: _____

Pharmacy of Choice: _____ Phone: _____

In case of Emergency, who should be notified?: _____ Phone: _____

Primary Care Physician: _____

Do we have your permission to:

Leave a message on your answering machine at home?	☐ YES	☐ NO
Leave a message at your place of employment?	☐ YES	☐ NO
Discuss your medical condition with any member of your household?	☐ YES	☐ NO

If yes, whom: _____ Relationship: _____

_____ _____
Patient Signature Date

WHY ARE YOU HERE TODAY?
(PLEASE DESCRIBE WHAT THE PROBLEM IS, WHERE IT IS LOCATED, HOW IT BOTHERS YOU, WHEN IT FIRST BEGAN, WHAT IT FIRST LOOKED LIKE, WHAT YOU THINK CAUSED IT, WAS A BIOPSY DONE, AND ANY TREATMENT YOU HAVE HAD SO FAR.): _____

_____

_____

_____

_____

_____

Social History:

Occupation: _____

Hobbies: _____

- Do you wear: ☐ dentures ☐ glasses ☐ contact lenses
- Smoking: ☐ no ☐ former ☐ yes; how many packs/day? _____
- Alcohol or drug problems/addictions: ☐ no ☐ yes; describe: _____ _____

PHYSICAL EXAMINATION

NAME: _____ Date: _____

Medications:

Regular: _____

Occasional: _____

Aspirin last taken: _____ Blood thinners last taken: _____

Medication Allergies: _____

Past History:

- Previous Skin Cancer: ☐ none ☐ List: _____
- Other Medical Problems (including any major illnesses or hospitalizations): ☐ none ☐ List: _____

_____

ROS: check all that apply regarding your overall health and add any other important problems

- SKIN
  - normal
  - keloids
  - poor healing
  - other skin problems: _____
- HEMATOLOGICAL/ LYMPHATIC
  - normal
  - anemia
  - bleeding problems
  - enlarged lymph nodes
- CONSTITUTIONAL SYMPTOMS
  - none
  - weight loss
  - fever
  - other: _____
- EYES/EARS/NOSE/THROAT
  - normal
  - glaucoma
  - hearing aid
  - plastic surgery: _____

- CARDIOVASCULAR
  - normal
  - angina
  - artificial heart valve
  - pacemaker
  - hypertension
  - heart attack (when?) _____
- RESPIRATORY
  - normal
  - asthma
  - emphysema
  - other lung problem: _____
- GASTROINTESTINAL
  - normal
  - stomach ulcer
  - colitis
  - other GI problem: _____
- MUSCULOSKELETAL
  - normal
  - arthritis
  - artificial joint
  - other: _____

- NEUROLOGICAL
  - normal
  - stroke
  - seizures
  - other: _____ _____
- PSYCHIATRIC
  - normal
  - depression
  - anxiety attacks
  - other: _____ _____
- ENDOCRINE
  - normal
  - diabetes
  - thyroid problems
  - other: _____ _____
- INFECTIONS
  - none
  - hepatitis
  - HIV/AIDS
  - tuberculosis (T.B.)
  - other: _____

Family History (Skin Cancer): melanoma; other skin cancer (i.e. basal cell or squamous cell)
none
LIST: _____

Other Family Illnesses: _____

_____

_____

For office use:
Confirmed By: _____ Date: _____

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Protecting Your Health Information:
What you need to know about the Health Insurance Portability and Accountability Act

- Identity theft. Credit card fraud. Computer viruses. Concern for the privacy and security of personal information has never been greater. Our concern for safety and security of your personal health care information has never been taken more seriously. While we have gone to great lengths to ensure the privacy of your personal health information, we will soon be getting additional help from the Federal Government in the form of new regulations. The regulations will help to standardize privacy and security requirements across the country in all types of health care organizations.

New Regulations Passed: The regulations are part of the Health Insurance Portability and Accountability Act or HIPPA for short. HIPPA does three primary things:

1. It helps standardize and simplify the way health care organizations exchange electronic health care data.
2. It provides consumers with additional protections for getting and maintaining health insurance coverage; although, it does not guarantee coverage.
3. It creates new security rules to ensure the safety and privacy of individual health information and medical records.

- HIPPA ensures the privacy and security of individual health information. Currently, individual state laws govern use and disclosure of this information, creating many inconsistencies and gaps in the way your health information is protected. HIPPA sets minimum security and privacy standards for healthcare organizations to follow. If a state has more stringent privacy and security laws, then those would follow instead. In addition, HIPPA sets heavy penalties for violations of these standards and the misuse of personal health information.

- Every time you go to see a doctor, are admitted to a hospital, fill a prescription, or send a claim to an insurance company, a record is made of your confidential health information. This type of information is referred to as individually identifiable health information and is the type of information regulated by HIPPA. It can be in any format, electronic, paper or oral. Healthcare organizations that collect and manage this type of information and are therefore covered by these regulations including physicians, physical therapists, mental health professionals, dentists, chiropractors, optometrists, podiatrists, and others; hospitals, health plans, employers, healthcare clearing houses such as claims processors, and other healthcare organizations who conduct administrative and financial transactions.

- Under HIPPA, you have new rights to understand and control how your health information is used. Right to education: Healthcare providers and health plans are required to provide you with a clear written explanation of how the intend to use and disclose your information. Right to access medical records: You have the right to see and get copies of your medical records, request changes and receive a history on non-routine disclosures of your personal health information. Right to consent: Healthcare providers are required to obtain prior consent before sharing personal health information for purposes *other than* treatment, payment and healthcare operations. Right to recourse: You have the right to file a formal complaint if you believe that violations of the regulations were made.

In general, HIPPA tries to find a balance between protecting your privacy and allowing the appropriate flow of information between healthcare providers that is necessary for you to access care and receive quality healthcare services. Want to learn more? For a copy of our practice privacy protections, please ask the receptionist at the front desk. The following websites may also contain helpful information on HIPPA: American Medical Association, American Dental Association, American Chiropractic Association, American Optometric Association, American Podiatric Medical Association, and American Academy of Ophthalmology.

Debra B. Luftman, M.D., Inc. • Diplomat of The American Board of Dermatology

23975 Park Sorrento, Suite 355 • Calabasas, CA 91302 • tel. (818) 222-2055 • fax (818) 222-2821

416 North Bedford Drive, Suite 100 • Beverly Hills, CA 90210 • tel. (310) 275-4195

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HIPAA ACKNOWLEDGEMENT OF RECEIPT

My signature acknowledges that I have received the pamphlet about:

Protecting Your Health Information:
What you need to know about the Health Insurance Portability and Accountability Act (HIPAA)

If you have any questions once you have read this pamphlet, please do not hesitate to contact our office at the phone number listed below.

_____
Print Patient Name

_____ _____
Patient (or Guarantor) Signature Date

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CANCELLATION POLICY FORM

This notice will confirm arrangements for professional services made with our office. Our objective is to avoid any later misunderstandings about services or agreed charges.

Payment of services rendered is due at the time of your visit. Please make a note that our office requires a 24-hour advance notice of cancellation of an appointment. Your failure to provide our office with advance notice of cancellation of an appointment will result on a charge equivalent of 100% of what the charge would have been.

All appointments must leave a credit card on file.

Our office "attempts" to confirm appointments but this is not a guarantee. It is the patient's responsibility to remember their appointment.

_____ _____

Patient or Guarantor Signature Date

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E-MAIL ADDRESS UPDATE FORM

Dear Patient,

To update our records, and for upcoming newsletters and specials, please provide us with your e-mail address:

Patient Name: _____

E-Mail Address: _____

Date: _____

THANK YOU!

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