PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Date:_____

Patient Name: _____,_____ Date of Birth:_____ Sex: M F
LAST FIRST MI

Address_____ Marital Status___
STREET CITY STATE ZIP APT #

Preferred Daytime Phone: (_____)_____ Phone: (_____)_____
Circle: Home - Cell Home - Work - Cell

Email Address: _____ **Preferred Contact Method** (Circle One): Phone – Letter - Email

Social Security#:_____ Driver's License #_____Employer_____

Insurance Information:

PRIMARY Insurance carrier:_____ID#_____Group#_____

Subscriber Name:_____ ***Subscriber DOB***:_____/_____/_____

Subscriber SS#_____-_____-_____ Sub. Employer:_____ Relationship to insured_____

SECONDARY Insurance carrier:_____ID#_____Group#_____

Subscriber Name:_____ ***Subscriber DOB***:_____/_____/_____

Subscriber SS#_____-_____-_____ Sub. Employer:_____ Relationship to insured_____

As a patient or legal guardian of a minor patient*, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. **ASSIGNMENT & RELEASE:** I hereby authorize payment of medical and/or surgical benefits directly to Peninsula Dermatology Medical Grp., Inc. for services rendered. I understand that I am financially responsible for charges not covered or denied by my insurance for whatever reason - See Financial Policy Form. I authorize this office to release any information necessary to process this request.

SIGNATURE _____ DATE:_____

If the patient is a minor* (under the age of 18) <u>authorizing parent</u> information **REQUIRED below (Please print)

*Parent Name:_____ *Date of Birth:____/____/_____
LAST FIRST MI

*Address:_____ *Relationship to patient_____
STREET CITY STATE ZIP APT #

*Social Security#:_____ Daytime Phone: (_____)_____Phone: (_____)_____
CIRCLE: Home - Work - Cell Home - Work - Cell

Acknowledgement of Receipt of Notice of Privacy Practices

I have read the Privacy Notice and understand my rights contained in the notice.
By way of my signature below, I provide this practice with my authorization and consent to use and disclose my Protected Healthcare Information (PHI) for the purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.

If you would like to authorize anyone to receive or give information about you, please complete:

I hereby authorize Peninsula Dermatology Medical Group, Inc. to disclose information about me to:

_____
Name(s)

_____
Relationship to patient (Spouse/Child/Parent/Conservator, etc)

Or _____ Initial if you do *NOT* want your medical information to be shared with anyone other than your team of physicians and insurance company, when necessary.

If you are signing as the patient's representative:
**Print your name:* _____ *Describe your authority/relationship to patient:* _____

_____ _____
Patient's Signature (Or authorized parent/representative) **Date**

peninsula dermatology
medical group, inc.

Name: _____ Date of Birth _____

Preferred Language: _____ Primary Care Doctor: _____

Referring Source (Check All Applicable): _____ Referring Doctor: _____

☐ Doctor ☐ Family/Friend ☐ Yelp ☐ Other Race: _____

Emergency Contact Name: _____ Ethnic Group (Circle One):

Emergency Contact Number: _____ Decline to Specify – Hispanic/Latino - Not Hispanic/Latino

Preferred **Pharmacy Name:** _____

Pharmacy Location: _____ Pharmacy Phone: _____

******For Age 65 or older only:** Do you have Advanced Care Plan (Circle one): **YES** **NO**

*****Is it ok to leave a detailed message?** (Circle one) **YES:** Cell / Home / Work **NO**

Medications: (Please enter all current medications, dose not required) If none, circle: **NONE**

Drug Allergies: If none, circle: **No Known Drug Allergies**

Past Surgical History: If none, circle: **NONE**

Social History: (Please circle all that apply)

Cigarette Smoking:

Current every day smoker Never smoked
Current someday smoker Former smoker

Alcohol Use:

Less than 1 drink per day 1-2 drinks per day
3 or more drinks per day NONE

Do you have a present illness of:

Problems with bleeding	Yes	No
Problems with healing	Yes	No
Problems with Scarring (keloid/hypertrophic)	Yes	No

Past Medical History: (Please circle all that apply)

Anxiety	Autism Spectrum Disorder	Depression
Organ Transplant	Arthritis	Hyperthyroidism
Asthma	Diabetes	Hypothyroidism
Atrial fibrillation	End Stage Renal Disease	Leukemia
Bone Marrow Transplant	GERD	Lung Cancer
Breast Cancer	Hearing Loss	Lymphoma
BPH	Hepatitis	Prostate Cancer
Colon Cancer	High Blood pressure	Radiation Treatment
COPD	HIV/AIDS	Seizures
Coronary Artery Disease	High Cholesterol	Stroke

Other_____

Skin Disease History: (please circle all that apply)

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

Other_____

Do you wear Sunscreen?	Yes	No	If yes, what SPF? _____
Do you have history of tanning bed use?	Yes	No	
Do you have ***family history*** of Melanoma?	Yes	No	If yes, Relationship: _____
Do you have ***personal history*** of Melanoma?	Yes	No	If yes, date/year of Diagnosis _____
Do you have ***family history*** of other skin cancer?	Yes	No	
Do you have ***personal history*** of other skin cancer?	Yes	No	

Please Circle:

Allergy to adhesive	Yes	No	Allergy to lidocaine	Yes	No
Artificial heart valve	Yes	No	Artificial joints	Yes	No
Blood thinners	Yes	No	Defibrillator	Yes	No
MRSA	Yes	No	Pacemaker	Yes	No

Allergy to topical antibiotic ointments	Yes	No
Premedication prior to procedures	Yes	No
Rapid heartbeat with epinephrine	Yes	No
Pregnant or planning pregnancy	Yes	No
Breastfeeding	Yes	No
West Africa: Travel or Contact	Yes	No
Ebola risk: Contact, Travel, Sickness?	Yes	No
***History of fainting, anxiety, or dizziness when receiving medical treatment?	Yes	No

PENINSULA DERMATOLOGY MEDICAL GROUP, INC.

Diseases of the Skin • Dermatologic Surgery • Laser Surgery • Mohs' Surgery

1750 El Camino Real #206, Burlingame, CA 94010 Tel (650) 692-0182 Fax (650) 692-8116

Dear Patient:

Welcome to our office. It is the policy of Peninsula Dermatology to follow all federal and state laws and reporting requirements regarding identity theft. Please be informed that it is a **requirement that you bring a photo ID** issued by a local, state or government agency (valid driver's license, passport, employee ID card, student ID card or current utility bill if photo ID is not available) to your appointment. If the patient is a minor, the patient's parent/ guardian should bring the information listed above. You will also need **your insurance card, referral/authorization** if needed, and any **co-payment** that is due. **Please note if you do not have your insurance card with you, our office policy treats you as a "cash pay" patient and you will be required to pay at the time of your visit. We do not accept personal checks.**

Cancellations/Reschedules/No Shows: If you are unable to keep your appointment, we ask that you kindly provide us with at least 48 hours notice. This courtesy, on your part, will make it possible to give your appointment to another patient. If you do not call to cancel or reschedule your appointment within 24 hours there will be a $ 100.00 fee.

Thank you for your cooperation and assistance complying with the above requests.

Providers and Staff of Peninsula Dermatology Medical Group

I have read and understand the above policy:

Patient Name Signature Date

PENINSULA DERMATOLOGY MEDICAL GROUP, INC.

FINANCIAL POLICY

We are committed to providing you with the best possible medical care and are pleased to discuss our professional fees with you at any time. Our billing department can be reached directly by calling (650) 692-0789. Your clear understanding of our financial policy is important to our relationship.

All patients must complete our patient information sheet and supply us with a copy of their insurance card(s) with proof of identification on a yearly basis. If any information has changed during the year, we will ask that you fill out new forms and allow us to take copies of your new insurance card(s).

Payment at the time of service is required as follows:

HMO Patients:	Co-payment, if applicable, provided you or your PCP/Medical Group has furnished us with proper authorization/referral for treatment.
PPO/POS Patients:	Co-payment, if applicable and/or annual deductible amount. Please note, if we are not contracted with your 1st tier medical group, e.g., Mills Peninsula or Brown and Toland Medical Group, the claim will be submitted using your "out of network" benefits. Co-insurance and deductibles will apply.
Cash Patients:	Payment in full is due at the time of service unless a prearranged financial agreement has been arranged.
Cosmetic Procedures:	Payment for all cosmetic procedures are due at the time of service and are not billable to your insurance company.

If you do not have the proper authorization/referral or if this is pending and/or you do not have proof of insurance (no insurance card) you will be treated as a "Cash Patient". _____ (please initial)

We accept Cash, Visa, MasterCard and Discover. We do not accept personal checks.

Billing Your Insurance:
As a courtesy to you, we will bill your primary and secondary insurance only. However, to do so, we must have the most up to date insurance cards provided to us prior to services being rendered otherwise; payment in full will be required. _____ (please initial)

We will not become involved in disputes between you and your insurance company regarding eligibility, deductibles, co-payments, covered charges, etc. other than to supply pertinent medical information as required.

You are responsible for timely payment of your account.

Thank you for reviewing our policy. Please bring questions or concerns to the attention of our billing office.

Please sign below as an indication that you have read and agree to the above Financial Policy.

Patient/Guardian (Print) (Signature) Date

Street Address City State Zip

1750 El Camino Real, Suite 206, Burlingame, CA 94010
650-692-0182 (Fax) 650-692-8116

peninsula dermatology
medical group, inc.

Kaiser Insurance Billing Acknowledgment and Financial Responsibility Agreement

Patient Name: _____ **Date of Birth:** _____

We are a **private dermatology practice** and **do not have any contractual relationship with Kaiser Permanente or any of its affiliates**. As such, we do **not** accept, bill, or coordinate benefits with **Kaiser insurance** under any circumstances.

PLEASE READ CAREFULLY:

1. **We do not and will not bill Kaiser Permanente** for any services rendered at this practice.
2. If Kaiser is your **primary insurance**, even if you provide us with another secondary insurance plan that we do accept, **you will be fully responsible for the entire cost of the visit and any related charges**.
3. If you fail to disclose Kaiser as your primary insurance, or do not provide accurate insurance coordination of benefits (COB) information, and Kaiser is later determined to be primary, **you will be held financially responsible for the full balance**.
4. If you are a Kaiser member and still wish to be seen, you may do so on a **private pay (self-pay) basis**. Full payment is due at the time of service.
5. We will **not retroactively bill Kaiser** under any circumstance. You may attempt to submit a claim to Kaiser on your own, but we will not assist with or submit any documentation directly to Kaiser.
6. By signing below, you acknowledge and agree to these terms, and you accept full financial responsibility for any services rendered at our practice in the event Kaiser is, or is later found to be, your primary insurance.

Patient Acknowledgment & Signature

I, the undersigned, have read and understand the above policy. I acknowledge that Peninsula Dermatology Medical Group does not bill Kaiser insurance and that I am fully responsible for any charges incurred if Kaiser is determined to be my primary insurance. I understand that I may be required to pay out-of-pocket and that submission of any claims to Kaiser will be my sole responsibility.

Patient Signature: _____ **Date:** _____

Printed Name: _____

MEDICARE RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Medicare requires this office to have this statement signed by all MEDICARE patients and kept in their medical record. By signing this statement, you are giving Medicare, or its representative, permission to examine your medical record. You have the right to refuse to sign this form but we must have your refusal in writing.

I request that payment of authorized Medicare and/all secondary insurance benefits be made on my behalf to Peninsula Dermatology Medical Group, Inc. for any services furnished to me by the medical group's physicians. I authorize any holder of medical information about myself to release to the Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If Item 9 (other health insurance coverage) of the HCFA-1500 claim form is completed or elsewhere on electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and ***the patient is responsible for the deductible, co-insurance, and non-covered services***. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient Signature Date

_____ _____

Patient Printed Name Medicare Number

NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to

www.mbc.ca.gov,

email: licensecheck@mbc.ca.gov,

or call (800) 633-2322.

Date

Patient's Name (Type or Print)

Patient's Signature

Date

Patient Representative's Name and Relationship (Type or Print)

Patient's Representative's Signature

Original to be maintained in patient's medical records.

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or call (800) 633-2322.

Open Payments Data

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at

https://openpaymentsdata.cms.gov.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.