PATIENT DEMOGRAPHIC FORM

Patient Name: _____

LAST NAME FIRST NAME MIDDLE NAME

Marital Status (circle): Single Married Widowed Divorced Partnered

Patient's Date of Birth:_____ **Age:**____ **BioL Gender:** M F **SSN#:**_____

Primary Language: _____ **Pronouns:** _____

Address: _____

STREET APT/UNIT # CITY STATE ZIP CODE

Telephone: _____

HOME (xxx) xxx-xxxx WORK (xxx) xxx-xxxx MOBILE (xxx) xxx-xxxx

Pharmacy : _____

Email Address: _____

Employer: _____

EMPLOYER NAME EMPLOYER ADDRESS

Emergency Contact: _____

FULL NAME RELATIONSHIP TO PATIENT PHONE NUMBER

Primary Care Physician: _____

LAST NAME FIRST NAME PHONE NUMBER

Referring Physician: _____

If a Physician did not refer you, please tell us how you heard about our office

MPZ Dermatology Website **Online Review** **Social Media** **Insurance Carrier** **Referral/Word of Mouth**

Parent/Guardian: _____

PARENT/GUARDIAN NAME DAYTIME PHONE RELATIONSHIP TO PATIENT ALTERNATE DAYTIME PHONE

Primary Insurance	**Secondary Insurance**
PRIMARY INSURANCE COMPANY NAME	SECONDARY INSURANCE COMPANY NAME
SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT	SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT
SUBSCRIBER'S ID NUMBER	SUBSCRIBER'S ID NUMBER
GROUP NUMBER SUBSCRIBER'S BIRTHDATE	GROUP NUMBER SUBSCRIBER'S BIRTHDATE
PLEASE INDICATE RELATIONSHIP TO PATIENT Self Spouse Father Mother Partner Other	PLEASE INDICATE RELATIONSHIP TO PATIENT Self Spouse Father Mother Partner Other

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

Patient Skin Concerns

What are you most concerned about regarding your skin?

_____

_____

_____

Medical History:

Are you in good health now?

Yes No

Have you ever had any of the following?

Asthma	Yes	No	Diabetes	Yes	No
Chronic Hay Fever	Yes	No	Internal Cancer	Yes	No
Hives	Yes	No	High Blood Pressure	Yes	No
Sinus Problems/Migraines	Yes	No	Heart Trouble	Yes	No
Eczema	Yes	No	Rheumatic Fever	Yes	No
Boils	Yes	No	Jaundice/Hepatitis	Yes	No
Food Allergies	Yes	No	Kidney Disease	Yes	No
Allergy to Local Anesthetics	Yes	No	Glaucoma	Yes	No
Bleeding Ulcer	Yes	No	Epilepsy	Yes	No
HIV Infection	Yes	No	Tuberculosis	Yes	No
Do You Smoke?	Yes	No	Organ Transplant	Yes	No
Joint Replacement	Yes	No			
Do you take blood thinners?	Yes	No	(Blood Thinners like Aspirin, Advil, Ibuprofen, Motrin, Coumadin)		
Have you ever taken Penicillin?	Yes	No			

What disease, if any, runs in your family?

Have you ever been treated for skin cancer?

Yes No

Female Patients:

When was your last menstrual period? _____

Are you pregnant? Yes No

If yes, how many months?

Are you breast-feeding? Yes No

PATIENT MEDICATION LIST

Medication Name/Dosage/Frequency/Route of Administration (e.g., oral, topical, inhaled)

Medication Name	Dosage	Frequency	Route of Administration

○ CHECK HERE IF NONE

Patient Medication Allergies (If none, write NKDA for "No Known Drug Allergies.")

_____

_____

_____

MPZ
DERMATOLOGY

Medical Records Release Form

As required by the health information Portability and Accountability Act of 1966 (HIPPA) and California Law, MPZ Dermatology may not use or disclose your individual identifiable health information except as provided in our notice of privacy practices without your authorization. Your completion of this form means that you're giving your permission for the use disclosure described below. Please be aware that once your information leaves MPZ Dermatology, we will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.

I hereby, release MPZ Dermatology from any / all legal liability that may arise from the release of this information to the party listed below. Further, I authorize MPZ Dermatology to obtain or disclose health information concerning:

Patient Name: _____ Date of Birth: _____

Health Information to be released or Disclosed

(Circle One)

History/ Physical Telephone Messages Lab Results Entire Medical Records X-Ray Results

Consultation Report Progress Notes Biopsy/ Surgical Pathology Site _____

_____

_____

I understand this information may include information relating to AIDS (acquired immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) infection, STDs (Sexually Transmitted Diseases), and treatment for alcohol and/ or drug abuse.

Please make sure that all physician or contact information is filled out completely. Requests with missing information will not be honored.

_____Initials

Information to be released to:

_____

_____

_____

From:

_____

_____

_____

I understand this authorization may be revoked in writing at any time, according to MPZ Dermatology's Notice of Privacy Practices. Unless otherwise revoked, this authorization will expire One year from date of this authorization.

Printed Name: _____ Date: _____

Signature: _____ Witness: _____

If signed by other than the patient, indicate the relationship: _____

Patient Acknowledgement and Authorizations

I authorize MPZ Dermatology to conduct examinations and perform procedures that are medically required to administer treatment and medications as deemed necessary or advisable.

MPZ Dermatology is hereby authorized to release a complete report of services rendered, diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billing agents, insurance carriers, employer's workers' compensation insurance company, other third-party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other Intermediaries responsible for payment of services rendered. The release of information consent may be revoked at any time by giving written notice.

If the release of information is refused, the patient will be held responsible for payment of all charges for services rendered. In consideration of medical goods and services provided by the MPZ Dermatology, I give all rights, title and interest to the medical/surgical/supply reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefits including Medicare Part B. I remain fully responsible for payment of any, and all charges not covered by insurance or Medicare.

Patient Assignment for Benefits

MPZ Dermatology will bill all primary and secondary insurances, but I am ultimately responsible for payment for the services and any products I receive.

I hereby assign to MPZ Dermatology any insurance or other third party benefits available for healthcare services provided to me. I understand that MPZ Dermatology has the right to refuse or accept assignments of such benefits. If these benefits are not assigned to MPZ Dermatology, I agree to forward to MPZ Dermatology all health insurance and other third-party payments that I receive for services rendered to me immediately upon request.

I understand that my signature requests payment be made directly to MPZ Dermatology. I authorize the release of medical information necessary to pay the claim. A photocopy of this assignment is to be considered as the original.

Patient Financial Policy

Thank you for choosing MPZ Dermatology as a healthcare provider. We are committed to your treatment being a successful experience. Please help us maintain accurate records by filling out forms legibly and informing us if any changes need to be updated on your account (for example: address, telephone number, medical insurance, etc.).. Copayments are due at the time of service. MPZ Dermatology reserves the right to send specimens to an outside laboratory for special staining purposes, pathological interpretation, and/or to obtain a second opinion. MPZ Dermatology is not responsible for any outside facility charges that may be incurred. It is your responsibility to know and understand your specific insurance plan and what benefits are provided. There is a $50 fee if appointments are not canceled or rescheduled within 24 hours of your appointment. We accept all major credit cards, debit cards and cash. We DO NOT ACCEPT payment by check. Please review MPZ Dermatology complete Patient Financial Policy attached for more information.

I have read and agree with the Patient Acknowledgment and authorizations, Assignment of Benefits, and Financial Policy (see details below). I understand the terms and conditions outlined herein as confirmed by my signature below.

PATIENT OR GUARDIAN SIGNATURE DATE

Notice of Privacy Practices

By my dated signature below I acknowledge that I have hereby been made aware that I can either request a physical copy of MPZ Dermatology's current Notice of Privacy Practices for review in the reception area upon my visit to the clinic, or read and download an online copy with updated amendments, as they may be made from time to time, from our website at www.mpzderm.com. Our Privacy Practices include the way we handle your personal and private medical information as regulated by the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPPA). Questions regarding the Privacy Practices of MPZ Dermatology should be directed at our Privacy Officer, Natalie DeRose. She can be reached at our Corona Office.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices includes information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You acknowledge that by your dated signature below that you have been given an opportunity to review our notice, either physically or online, before signing this consent. The terms of the notice may change, if so, you will be notified on your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction in all circumstances, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law makes important exceptions to patient privacy you should be aware of. For example, HIPPA **allows for the use and sharing of Private Patient Information for treatment, payment, or healthcare operations** with laboratories, other physicians who you see or who we may consult, insurance carriers, and billing services. Other less common examples of exceptions include law enforcement or state and federal health care agencies.

By signing this form, you consent to our use and disclosure of your protected healthcare information as provided by HIPPA. You understand that not consenting may restrict our ability to provide you with care and have your insurance pay for our services. You have the right to revoke this consent in writing, signed by you, at any time. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information **may be disclosed or used for treatment, payment, or healthcare operations**.
- MPZ Dermatology reserves the right to change their privacy policy **as permitted by law**.
- The patient has the right to restrict the use of the information, but the practice **does not** have to agree to those restrictions **if they interfere with requirements dictated by federal law**.
- The patient has the right **to revoke this consent in writing** at any time and all full disclosures will then cease.
- The practice **may condition receipt of treatment** upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home, or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

PATIENT OR GUARDIAN SIGNATURE DATE

Patient Financial Policy

Thank you for choosing MPZ Dermatology as a healthcare provider. We are committed to your treatment being a successful experience. Please help us maintain accurate records by filling out forms legibly and informing us if any changes need to be updated on your account (for example: address, telephone number, medical insurance, etc.). You may contact our Billing Department at (714) 470-2471 Monday - Friday from 10:00AM to 3:00PM. We accept all major credit cards, debit cards and cash.

Insurance and Insurance Collection

If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay for services at the time of service. We will provide you with the required diagnosis and charge codes so that you may file a claim with your carrier.

Know Your Plan Benefits – Non-Covered Services Are Your Responsibility

Each insurance company, including Medicare and Medical, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have related to your own benefits. All co-payments, co-insurance, and/or deductibles are your responsibility. Co-payments are due at the time of service. This is a requirement of your insurer.

We may decline to see patients for non-emergency visits if co-payments are not made at the time of the visit. In addition, please be aware that your MPZ Dermatology provider may provide services not covered as a benefit of your specific insurance plan. Patients or Guarantors are financially responsible for all services provided that may not be covered by your insurance plan. It is your responsibility to know and understand your specific insurance plan and what benefits are provided.

You may undergo some procedures that are best performed utilizing the equipment, safety, and comfort that can be obtained in an Ambulatory Surgery Center (ASC) setting. Please be aware that these charges are separate and apart from those fees charged by MPZ Dermatology. You should ask your insurance company how your benefit plan would cover any outpatient facility/ASC charges.

You may undergo some procedures that will involve removing tissue. The charges for this process are known as Laboratory/Pathology charges and will appear on your bill if performed. The physician who looks at the slide and provides his/her opinion based on those slides is known as the Pathologist. There is a charge for that physician's professional opinion, which is independent of the charge for preparing the actual slide. MPZ Dermatology reserves the right to send specimens to an outside facility for special staining purposes, pathological interpretation, and/or to obtain a second opinion. MPZ Dermatology is not responsible for any outside facility charges that may be incurred.

HMO Plans

If your care and treatment at MPZ Dermatology is the result of a referral from your HMO plan and/or from your Medical Group or HMO Provider, you should have a written authorization/referral from them. It is your responsibility to verify that they properly authorize your care and treatment in advance. Any co-pay required will be your responsibility at the time of each visit.

Secondary Insurance

Having more than one insurance does NOT necessarily mean that your services are covered 100%. Depending on your plan's benefits, the secondary insurers will pay depending on what your primary insurer pays. We will bill your secondary insurer as a courtesy. You are responsible for any balances after your insurers have processed our claims.

Medicare

You are responsible for your annual deductible and 20% of the allowable fee for covered services. We will be happy to bill what remains after your claims have been processed and will transfer responsibility for payment to you and send you a statement.

Important reminder for Medicare-enrolled patients: If you are qualified for Medicare coverage and decided to enroll in a Medicare Choice/Medicare Advantage plan (e.g. Secure Horizons, Blue Cross Senior Secure, SCAN) you may need to first get a referral from your Primary Care Physician (PCP) before your visit with us will be covered. Please call the number on your insurance card for information from that plan

Minor Patients

The adult accompanying a minor and the minor's parents or guardians are responsible for full payment for services rendered. If a minor is unaccompanied, consent for treatment and payment arrangements must be provided in advance of treatment. Payment may be by pre-authorized credit card, payment on account in advance, cash or credit card presented at the time of service.

Divorce Decrees

MPZ Dermatology is NOT a party to any divorce decree. Adult patients are responsible for their bill at the time of service. Financial responsibility for a minor receiving medical services rests with the accompanying adult.

Payment Due at Time of Service

Payment for all services is due at the time the service is performed. If paying with a credit card, we require patients to provide a credit card for payment of co-payments, co-insurance amounts, deductibles, and charges otherwise not covered by your insurance. You will receive the same Explanation of Benefits (EOB) directly from the insurance company or Medicare. Once we have processed your payment, you will receive a statement from us reflecting that payment.

Collections

MPZ Dermatology will send you a statement after your insurers have been billed and your insurers have considered your charges. If no payment is received after 120 days, your account may be turned over to a collection agency. A $25.00 late payment/pre-collection fee will be added to your account to offset the administrative costs incurred when accounts are assigned for collection.

Missed Appointments

There is a $50.00 missed appointment fee if you cancel or reschedule an appointment with less than 24-hour advance notice, or if you fail to arrive for your appointment. Please do not rely on our automated appointment reminder service as your only reminder to keep your scheduled appointment, as we cannot guarantee this service, or that the phone number provided is accurate or functional for this purpose.

Promotional Coupons/Incentives

Some manufacturers offer certain discounted products and/or services. MPZ Dermatology may not honor or accept every coupon or manufacturer's offer as the terms and performance of the issuer may change. You are responsible for any goods and/or services you receive. Please ask whether any coupons are still being honored before receiving services. Cosmetic procedure refunds paid by credit or with debit card will be subject to a 5% processing fee, which will be subtracted from the total refund amount.

Request for Medical Records

A signed release of records form is required at the time of your request. You will be charged $0.25 cents per page copied, plus clerical fees of $25.00. If you request the records to be mailed to you, please note that postage fees are not included, and will be charged separately. The medical records will not be released to you until our fees are paid in full. These fees are set by the State of California (Health & Safety Code section 123110), not MPZ Dermatology.

PATIENT OR GUARDIAN SIGNATURE

DATE