PALO ALTO
DERMATOLOGY
INSTITUTE

Patient Demographic Form

Patient Name Mr. Mrs. Ms. Dr. Rev. ______________________________

LAST NAME FIRST NAME MIDDLE NAME

Patient's Date of Birth __________ **Age** ______ **Gender** M F ______________

xx / xx / xxxx SOCIAL SECURITY NUMBER

Birthplace ______________________ **Primary Language** ______________________

Address ____

STREET APT / UNIT # CITY STATE ZIP CODE

Telephone __________ __________ __________

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

Email Address ______________________ **Marital Status** (circle) Single Married Widowed Divorced Partnered

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

Palo Alto Dermatology Institute Website Online Review Website Social Media ZocDoc Insurance Carrier Referral/Word of Mouth

Parent/Guardian ____

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

Primary Insurance

____
PRIMARY INSURANCE COMPANY NAME

____
SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT

____
SUBSCRIBER'S ID NUMBER

____
GROUP NUMBER SUBSCRIBER'S BIRTHDATE

Self Spouse Father Mother Partner Other

PLEASE INDICATE RELATIONSHIP TO PATIENT

Secondary Insurance

____
SECONDARY INSURANCE COMPANY NAME

____
SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT

____
SUBSCRIBER'S ID NUMBER

____
GROUP NUMBER SUBSCRIBER'S BIRTHDATE

Self Spouse Father Mother Partner Other

PLEASE INDICATE RELATIONSHIP TO PATIENT

PATIENT OR GUARDIAN SIGNATURE ______________________________ **DATE** __________

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PATIENT NAME ______________________ DOB ______________

Patient Acknowledgment and Authorizations

I authorize the Palo Alto Dermatology Institute to conduct examinations, and perform procedures as are medically required to administer treatment and medications as deemed necessary or advisable.

The Palo Alto Dermatology Institute 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 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 Palo Alto Dermatology Institute, 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 of Benefits

Palo Alto Dermatology Institute will bill all primary and secondary insurances, but I am ultimately responsible for payment for the services and any supplies/equipment I receive.

I hereby assign to Palo Alto Dermatology Institute, any insurance or other third party benefits available for healthcare services provided to me. I understand that the Palo Alto Dermatology Institute has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Palo Alto Dermatology Institute, I agree to forward to the Palo Alto Dermatology Institute 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 the Palo Alto Dermatology Institute. I authorize 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 the Palo Alto Dermatology Institute, 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 inform us if any changes need to be updated on your account (for example: address, telephone number, medical insurance, etc). We require credit or debt card information to be left on file for future balance billing purposes. Copayments are due at the time of service. Palo Alto Dermatology Institute reserves the right to send out specimens to an outside laboratory for special staining purposes, pathologic interpretation, and/or to obtain a second opinion. Palo Alto Dermatology Institute 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 $150 fee if appointments are not canceled or rescheduled within 24 hours of your appointment. Cosmetic appointments longer than 30 minutes require a minimum $150 deposit (excluding prepaid packages), applicable to the treatment cost. This fee is forfeited without canceling or rescheduling with a minimum of 24 hours notice. We accept all major credit cards, checks, and cash. Please review Palo Alto Dermatology Insitute's 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. I understand the terms and conditions outlined herein as confirmed by my signature below.

PATIENT OR GUARDIAN SIGNATURE: ______________________________ Date: ______________________

PALO ALTO DERMATOLOGY INSTITUTE

PATIENT NAME ______________________________ DOB ____________________

Channel of Communication Request

You have the right to request how we communicate with you. We may communicate with you by phone, text, email, or US Mail including use of automated communication devices. I hereby request the use of the following communication channels for information related to my personal health, treatment, or payment for treatment. This request supersedes any prior request for confidential communications I have made. This permission is valid for one year from the date signed. You may revoke your authorization to receive further calls or messages at any time. The revocation does not have to be in writing. The ability to receive treatment from Palo Alto Dermatology Institute is not contingent upon your communication choices

Please circle all that apply and indicate with options(s) you prefer:

Preferred Contact Method (Circle all that apply): Phone Email Text

Primary Phone (______)_______-__________ Alternate Phone (______)_______-__________

_____________ DO NOT leave messages on my voicemail

_____________ OKAY TO leave messages on my voicemail

If you are unavailable, Palo Alto Dermatology Institute has permission to speak with: ______________________________________

Email for Marketing Purposes Yes / No Preferred Email Address: ____

Notice of Privacy Practices

I hereby acknowledge that I was offered and/or received a copy of Palo Alto Dermatology Institutes's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Any questions regarding the Privacy Practices of Palo Alto Dermatology Institute should be directed to our Office Manager, Darien Whang. He can be reached via email at **darien@paloaltoderm.com.**

I would like to receive a copy of any amended Notice of Privacy practices (circle one): Yes / No

I prefer to receive a copy via (circle one) Email Handout Mail Fax

PATIENT OR GUARDIAN SIGNATURE: ____ Date:_______________________

Discrimination is Against the Law

Palo Alto Dermatology Institute complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, or sex. Palo Alto Dermatology Institute does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, or sex.

Palo Alto Dermatology Institute:

1) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   (a) Qualified sign language interpreters
   (b) Written information in other formats (large print, audio, accessible electronic formats, other formats)

2) Provides free language services to people whose primary language is not English, such as:
   (a) Qualified interpreters
   (b) Information written in other languages

If you need these services, please call our office and ask to speak with the Office Manager. If you believe that Palo Alto Dermatology Institute has failed to provide these services or discriminated against in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Darien Whang, 301 High Street Palo Alto, CA 94301, (650) 969-5600.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Darien Whang is available to help you. You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office of Civil Rights: Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

STAFF USE ONLY

Sent/Given Copy By _______________

Date _____________

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PATIENT NAME ______________________ DOB ______________

Patient Medical History Form

Are you in good health now? Yes ______ No ______

Have you ever had any of the following?

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

What disease, if any, runs in your family?

____

____

Have you ever been treated for skin cancer?

Yes ______ No ______

If allergic to any medication, please list and state the reaction:

____

____

Serious Illness? If so, please describe below:

____

____

Previous skin problems? Please describe below:

____

____

Any hospitalizations? If so, please describe below:

____

Any surgeries? If so, please describe below:

____

Women only, please answer the following:

Are you pregnant? Yes ______ No ______ If yes, the expected delivery date is ______________

Are you breast-feeding? Yes ______ No ______

Do you take birth control pills? Yes ______ No ______ Name of brand? ______________

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PATIENT NAME ______________________ DOB ____________

Patient Medication List

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

Patient Skin Concerns

Skin Concerns (check all that apply)

____ Brown Spots/Age Spots
____ Fine Lines/Wrinkles
____ Pore Size
____ Scarring/Acne Scars
____ Skin Texture/Skin Tone
____ Torn Earlobe
____ Veins/Broken Capillaries
____ Varicose Veins
____ Loose Sagging Skin
____ Frown Lines
____ Freckles/Pigmentation
____ Heavy Wrinkle Reduction
____ Sun Damage
____ Skin Redness
____ Sagging or Puffy Eyelids
____ Excessive Sweating
____ Hair Loss
____ Neck Fat/Excessive Skin
____ Under Eye Circles
____ Unwanted Mole
____ Skin Tightening
____ Complexion
____ Lip Volume
____ Older Looking Hands
____ Cellulite
____ Hair Removal
____ Belly Fat/Spare Tire
____ Facial Volume Loss
____ Nose Shape or Contour
____ Jawline Definition
____ Unwanted Arm/Thigh Fat
____ Breast Enlargement/Reduction
____ Jowls or Weak Chin
____ Nail Fungus
____ Neck Skin
____ Fat Reduction

Specialty Services (check those you are interested in)

____ Ultherapy
____ Cellulaze
____ Aesthetician Services
____ Liposonix, CoolSculpting, SmartLipo
____ Kybella
____ Thermage, Titan
____ DermaSweep
____ Injectables/Fillers
____ Dr Morganroth's Vertical Vector Facelift (Local Anesthesia)
____ Tattoo Removal
____ Mommy Makeover
____ Dermapen
____ Breast Reduction/Lift/Implant
____ Fraxel/IPL
____ miraDry
____ Face/Neck Rejuvenation
____ Laser Eyelid Rejuvenation

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Patient Financial Policy

Thank you for choosing the Palo Alto Dermatology Institute, 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 inform 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 (650) 969-5600, Monday - Friday from 8:00 AM to 5:00 PM. We accept all major credit cards, checks 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. If we are able to collect from your insurance company after you have fully paid your account, we will issue you a refund. We will gladly bill your insurance company, if contracted, as a courtesy. In the event that your insurance does not reimburse us within ninety (90) days, we will transfer this balance to you as your responsibility and send you a statement.

Know Your Plan Benefits – Non Covered Services Are Your Responsibility

Each and every insurance company, including medicare, has different plans, each with different benefits. Because your health insurance i s 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 relative 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-emergent visits if co-payments are not made at the time of the visit. In addition, please be aware that your Palo Alto Dermatology Institute physician may provide services that may not be covered as a benefit of your specific insurance plan. Patients or Guarantors are financially responsible for any and 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.

Some procedures you may undergo 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 the physicians of the Palo Alto Dermatology Institute. You should ask your insurer how your benefit plan would cover any outpatient facility/ASC charges.

Some procedures you may undergo 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. Palo Alto Dermatology Institute reserves the right to send specimens to an outside facility for special staining purposes, pathologic interpretation, and/or to obtain a second opinion. Palo Alto Dermatology Institute is not responsible for any outside facility charges that may be incurred.

HMO Plans

If your care and treatment at the Palo Alto Dermatology Institute 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 as a function of 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.

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Medicare

You are responsible for your annual deductible and 20% of the allowable fee for covered services. We will be happy to bill and secondary (or Tertiary) insurance you may have once we have been informed that you have such coverage in effect. If any balance remains after your claims have been processed, we will transfer responsibility of payment to you and send you a statement.

Important reminder for Medicare enrollees: If you 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, or check or credit card presented at the time of service.

Divorce Decrees

Palo Alto Dermatology Institute 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.

Credit Card On File

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. The card will not be charged until the claim has been processed and we have received an Explanation of Benefits (EOB) detailing the amount of the charges that you are responsible for. You will receive the same EOB directly from the insurance company or Medicare. Once we have processed your credit card, you will receive a statement from us reflecting that payment. The credit card information will be held securely, and this process will be similar to cards on file during a car rental or hotel stay. If you prefer not to provide a credit card to be kept on file, you may pay for your services at the time of the visit.

Return Check Fee

There is a $25.00 banking fee for all returned checks. This sum is used to offset the fees incurred by Palo Alto Dermatology Institute by our bank. If your check is returned from the bank, we may NOT ACCEPT an additional check as payment on your account. Future payments must be made with cash, money order, or credit card.

Collections

Palo Alto Dermatology Institute will send you a statement after your insurers have been billed and your insurers have considered your charges. We will charge interest of 1.5% (18% annually) on all outstanding balances after 30 days. If no payment is received after 120 days, your account may be turned over to a collections 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 $150.00 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. Palo Alto Dermatology Institute may not honor or accept every coupon or manufacturer's offer as the terms and performance of the issue 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 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 Palo Alto Dermatology Institute.