Dermatology Associates of Berkeley
2320 Woolsey Street, Suite 202, Berkeley, CA 94705-1975

Patient Information Registration Form

Acct# _____ Title: _____ Patient Name _____ DOB _____ Sex _____

Address _____

Home # _____ Cell # _____ E-mail: _____

May We Leave Detailed Messages Including

Preferred # To Be Reached At _____ Diagnosis At This #? ☐ YES ☐NO

Preferred Language? _____ Race and Ethnicity: _____ ☐ Decline/Unknown

Social Security _____ Driver's License # _____ Marital Status _____

Emergency Contact _____ Relationship _____

Address _____ Phone# _____

Patient's Employer _____ Occupation _____

Primary Care Doctor _____ Phone# _____

Address _____ City _____ Zip Code _____

Insurance Information

Primary Ins: _____ Effective Date: _____ Phone # _____

Name of Insured: _____ DOB: _____ Relationship: _____

Address of Insured _____

ID# _____ Group # _____

Insurance Address _____

Secondary Ins: _____ Effective Date: _____ Phone # _____

Name of Insured: _____ DOB: _____ Relationship: _____

Address of Insured _____

ID# _____ Group # _____

Insurance Address _____

***Please note: If you are unable to keep your appointment, please allow 24 hour notice to avoid a charge. ***

Signature of Patient or Responsible Party _____ Date: _____

For Staff Use Only

Staff Initials _____ Date _____	Staff Initials _____ Date _____	Staff Initials _____ Date _____
Staff Initials _____ Date _____	Staff Initials _____ Date _____	Staff Initials _____ Date _____
Staff Initials _____ Date _____	Staff Initials _____ Date _____	Staff Initials _____ Date _____
Staff Initials _____ Date _____	Staff Initials _____ Date _____	Staff Initials _____ Date _____

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Please fill out the following health history. Thank you.

What skin problem do you wish the doctor to examine? _____

_____

Allergies:
Have you ever had an allergic reaction such as hives, a rash, asthma, fainting, or arthritis from any drug or medication?

Medication/Allergen	What Happened?	Medication/Allergen	What Happened?

Medications:
Please list ALL the medication that you are currently taking. This includes all over-the-counter and prescriptions as well as vitamins.

Medication (Please list strength)	How Much?	How Often?	Medication (Please list strength)	How Much?	How Often?

Do you use aspirin, ibuprofen (Motrin), naproxen, Plavix, Coumadin, warfarin, St. John's Wort, Ginko Biloba? Yes No

Personal Health History:
Please list <u>ALL health problems and chronic illnesses</u>: _____

_____

Previous Skin Cancer(s): ☐ none ☐ list type(s) and location(s): _____

Do you bleed excessively after small cuts or dental extractions? Yes No
Do you faint when given a shot? Yes No
Do you form keloids or large scars when you are cut? Yes No
Do you have seizures, epilepsy, or fainting spells? Yes No

Social History:
Previous sunlight exposure or sunburns: ☐mild ☐ moderate ☐ extensive ☐ tanning bed use
Do you smoke?: ☐ Never smoked ☐ Former smoker ☐ Daily smoker ☐ occasional smoker
Do you consume alcohol?: ☐ No ☐ Social/Occasional drinking only ☐ Daily

Family History:
☐ Acne ☐Psoriasis ☐Hairloss **Skin Cancer: ☐ None ☐ Melanoma ☐ Basal Cell ☐ Squamous Cell**

If so, who?: _____

For female patients:
Is there any possibility you could be pregnant? Yes No
Do you have menstrual periods? Yes No
Are they regular? Yes No

Patient Name (Print): _____

Signature: _____ **Date:** _____

Reviewed:

Dermatology Associates of Berkeley
2320 Woolsey Street, Suite 202
Berkeley, CA 94705
Ph: (510) 486-1700 Fax: (510) 486-1133

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION/SIGNATURE ON FILE
6 Year Consent Form (must be updated if patient is not seen in a 2-year period)

I hereby authorize Dermatology Associates of Berkeley to use and disclose my individually identifiable health information ("Health Information") in the manner described below. I understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.

Pharmacy Information

Preferred Pharmacy to send prescriptions to: Name: _____ Phone: _____

Pharmacy Address: _____

Appointment Reminders

Preferred method of receiving appointment reminders? Please make sure you provided the appropriate information on your demographics page.

☐ Email ☐Text Cell Phone Provider _____ .This grants us permission to send the text reminder.

Authorization for Record Release

Medical Information can be discussed with: ☐ Patient Only ☐ Family Member ☐ Other

Name: _____ Relationship: _____ Phone: _____

Account/Billing information can be released to: ☐ Patient Only ☐ Family Member ☐ Friend ☐ Other

Name: _____ Relationship: _____ Phone: _____

PLEASE READ & INITIAL

_____I understand that I am financially responsible for all cosmetic charges at the time of service.

_____I understand that I am financially responsible for all medical charges whether or not paid by health insurance.

_____I understand that I am responsible for understanding my medical insurance benefits and coverage.

_____I understand my medical insurance may not pay for routine labs (or) pathology tests (including biopsies).

_____By initialing, I authorize Dermatology Associates of Berkeley to submit medical claims to my insurance plan(s).

_____I authorize Dermatology Associates of Berkeley to act as my agent in helping me obtain payment from my insurance company.

_____I authorize payment directly to Dermatology Associates of Berkeley.

_____I have read and understand the billing policy for Dermatology Associates of Berkeley.

_____I have read the ***Notice of Privacy Practices,*** a federal privacy law created as a result of Health Insurance Probability Accountability Act of 1996 (HIPAA), (effective April 14, 2003).

Patient Name (PRINT): _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

If not signed by patient, patient, please indicate relationship: ☐ Parent, if patient is under 18 yrs of age ☐ Guardian, if patient is under 18 yrs of age

☐ Guardian or conservator of an incompetent patient ☐ Beneficiary of personal representative of deceased patient

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To our patients,

Please review our billing policy. We hope this will enable you to obtain your maximum insurance benefits and reduce billing expenses.

Always present your most current insurance card when checking in so that we may bill the appropriate insurance carrier with the correct information.

Contracted Insurance Groups:
If we are contracted with your insurance, we will bill all medically necessary office visits and procedures for you. Once we get a response from your insurance company, any deductibles or "patient responsibilities" will be billed to you. All co-pays are due at the time of check in. If a procedure is not considered medically necessary or is cosmetic, you will be responsible for payment **at the time of service.**

Non-Contracted Insurance Groups:
Payment is required at the time of service. We will provide you with necessary forms that you may submit to your insurance company for possible reimbursement. Procedures for filling claims varies depending on the insurance company. We suggest that you contact your carrier and inquire about their billing requirements.

Medicare:
We will bill Medicare and any secondary insurance you may have. Any unmet deductibles and fees for services not covered by Medicare or your secondary will be billed to you. If a procedure is not considered medically necessary or is cosmetic, you will be responsible for payment at the time of service.

Cash Paying Patients:
Payment is required at the time of service unless payment arrangements are made with the billing department **prior** to your appointment. We have made Visa and MasterCard payments available for your convenience.

Collection Policy:
All accounts over 90 days past due or any returned mail will be turned over to our collection agency, unless prior arrangements are made. There is a $25 collection fee applied to all accounts that are forwarded to the collection agency.

Pathology and Laboratory Fees:
All pathology specimens, (biopsies, excisions, removals, etc. except skin tags) are sent to a dermatopathologist for examination, usually the UCSF Dermatopathology lab. Fees for this and other lab services are billed by the respective lab and are independent of our fees. If you have insurance, we will submit the insurance information to UCSF or the lab for you. The portion of lab charges not covered by your insurance is your responsibility and will be billed to you by UCSF or respective lab.

If this policy creates financial hardship for you, please let us know. Our staff will assist you in making arrangements to satisfy your account in a way appropriate for you and our office.

I have read and understand the above billing policy.

Signature _____ **Date**_____