4955 Van Nuys Blvd. Suite 516
Sherman Oaks, CA 91403
Tel. 818.789.6296
Fax 818.789.0374

Patient Registration Form

First Name: _____ Last Name:_____

Date of Birth: _____ Age: _____ Gender:_____

Address: _____City: _____State: _____ Zip:_____

Cell: _____Home: _____Office: _____

Email: _____

Social Security: _____ Occupation:_____

Emergency Contact

Name: _____Relationship:_____

Cell: _____Home: _____Office: _____

Primary Physician

Physician Name:_____

Physician Phone:_____

Physician Address:_____

Referral

How did you hear about us?:_____

Assignment & Release

I, the undersigned, have Insurance with _____ (Name of your Insurance) and assign directly to LACA Dermatology, INC. all medical benefits. I understand that I am financially responsible for all charges that are not paid by my Insurance. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all my insurance submissions.

* ***Signature***:_____ ***Date***:_____

HIPAA Notice of Privacy Practices

I, the undersigned, fully understand that LACA Dermatology, INC. is required by law to maintain the privacy of my medical and health information. I acknowledge that the practice will use and disclose my health information for purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

****Signature***: _____ ***Date***:_____

LACA DERMATOLOGY, INC.
SKIN CANCER, GENERAL DERMATOLOGY, COSMETIC

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Medical History Form

Check (*please specify*) any of the following conditions which you have had or have been treated for:

- ☐ Heart Disease, Rheumatic fever
- ☐ Neurological disorder (MS, other)
- ☐ Liver or gallbladder disease, hepatitis
- ☐ Lung disease (COPD, TB, Asthma)
- ☐ High blood pressure
- ☐ Arthritis, Lupus, Joint replacement
- ☐ Eye disease (Glaucoma, corneal transplant)
- ☐ Other _____
- ☐ Cancer(type)_____
- ☐ Diabetes
- ☐ HIV/ AIDS
- ☐ Kidney Disease
- ☐ Stroke/ Heart attack
- ☐ Blood Disorder

Please state the reason for your visit today: _____

PLEASE LIST ALL ALLERGIES _____

Please list ***all*** medications you take including aspirin, vitamins, and over the counter medications.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please circle the following:

Do you smoke? *Please specify*: _____ YES NO

Do you have a pacemaker or defibrillator? YES NO

Do you take antibiotics before dental procedures? YES NO

Do you have a history of skin cancer? (Melanoma, BCC, SCC) YES NO

Is there a history of skin cancer in your family? (Melanoma, BCC, SCC) YES NO

Have you previously had a skin problem? *Please specify*: _____ YES NO

Prior Hospitalizations and surgeries (please give dates): _____

For women only (circle)

Are you pregnant? YES NO Are you breastfeeding? YES NO Taking Birth control? YES NO

Please inform the doctor if you plan to become pregnant or become pregnant during treatment

_____

***Signature:** _____ ***Date:** _____

LACA DERMATOLOGY, INC.
SKIN CANCER, GENERAL DERMATOLOGY, COSMETIC

WHAT IS A DEDUCTIBLE?

The amount you owe for health care services before your health insurance plan begins to help you pay your medical bills.

What does deductible mean to you?
It means that before your insurance company pays for any of your health services, you would have to meet a certain amount of payment. The actual deductible depends on your specific insurance coverage.

If I pay my Copay, do I still have to pay anything else when I see the doctor?
It depends on your insurance plan. Some insurance plans have a copay, deductible, and coinsurance. Some insurance plans have a $0 deductible whereas others have a $1,000 deductible. If you have a $1,000 deductible, you have to pay this in full before your insurance company will start to pay for your medical services.
Example: If the deductible is $1,000, the insurance won't pay for anything until you have paid $1,000 for covered health care costs. If you require surgery that costs $3,000, you would pay the $1,000 deductible, and the Insurance would now help pay a potion of the remaining $2,000 (based on the plan).

When the front receptionist tells me that "My Insurance covers the visit" or "I'm in network". What does this mean?
This means that your insurance company and our office have a contract to see you at a discounted rate. However this does NOT mean that you don't have to pay anything. All deductibles and copays still apply. This means the insurance company will not fully pay for your visit until you have fully paid and met your deductible.

Can LACA Dermatology, INC. check my deductible?
Yes, however the insurance companies do not always give us the most accurate information. The staff will check your insurance to confirm that we providers of your "network". However, our staff is not responsible for telling you about how much deductible you have or how much of it you have met. *This information is impossible to determine accurately and we do not want to be responsible for giving you inaccurate information. To determine the exact amount of your deductible, please contact your insurance carrier and talk to your insurance broker.*

I acknowledge that LACA Dermatology INC. can not accurately check my deductible. The office will only notify me whether "I am in Network or not". I understand that I may have to pay for all or a portion of my visit. I am responsible for any deductible I may have based upon the insurance policy I have purchased through my insurance broker.

_____ _____

Print name Date

_____

∗Signature

LACA Dermatology, Inc

An Important Message about your Insurance Coverage
Protect Your Insurance Benefits

In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way we can possibly know or keep up to date with each program's provisions.

*Some programs require a specific facility to be used to be eligible for benefits.

*Some programs require a patient to satisfy a deductible, co-insurance or other out-of-pocket expense before paying for claims.

*Some programs require pre-authorization while others do not.

*Some programs require a signed referral from your primary care physician for any consultations or treatments with a specialist physician.

*Some programs may require a second opinion.

It must be your responsibility to know and advise us of your program's requirements in advance, each and every time we provide a service. We will do our best to comply with any requirements that your program may have. Please understand that if we provide a service that is outside of your program, you will be responsible for the appropriate fees.

These are not our regulations, they are your insurance company's regulations and unless you follow them carefully the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to be used if you have any questions about your coverage.In an insurance policy, the **deductible** is the amount of expenses that must be paid out of pocket before an insurer will pay any expenses. It is normally quoted as a fixed quantity and is a part of most policies covering losses to the policyholder. The deductible must be paid by the insured, before the benefits of the policy can apply. Typically, a general rule is: the higher the deductible, the lower the premium and vice versa. Depending on the policy, the deductible may apply per covered incidents, or per year. For policies where incidences are not easy to delimit (for example health insurance), the deductible is typically applied per year.
In health insurance, **coinsurance** is sometimes used synonymously with the copayment, but is defined differently—a copay is typically fixed while the coinsurance is a percentage that the insured pays after the insurance policy's deductible is exceeded.
We are legally required by contract as a provider with your insurance company to collect copays and deductibles at the time of service for every visit.

I acknowledge receipt of this information.

Signature X_____ **Date**_____

Print Name: _____ **DOB:** _____

Cancellation Policy / No Show Policy

We would like to thank you for being a patient in our office. We value all of our patients and strive to provide the best dermatology care possible in the most comfortable setting. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change your appointment, please give us a 24 hour notice. This courtesy makes it possible to give your reserved time to another patient who would like it. If you are unable to keep an appointment we ask that you cancel at least 24 hours in advance. If this is not possible, please call us as soon as you can so that another patient can be given your appointment time.

We understand that occasional missed appointments can occur for a variety of reasons. When you miss an appointment without cancelling, someone else who could have been seen in your place is delayed unnecessarily. A "no show/ late cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a ***$25 charge*** for missed, late-cancelled, or non-cancelled appointments. Repeated missed appointments may result in needing to put down a non-refundable deposit to schedule future appointments.

Thank you,

LACA DERMATOLOGY, INC.

SKIN CANCER, GENERAL DERMATOLOGY, COSMETIC

_____	_____	_____
Print name	* Patient signature/ Guardian	Date

LACA Dermatology, Inc.

THIS PAGE IS MANDATORY

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance practices and policies.
If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. Co-payment, Deductible, Co-insurance), we are legally required to collect these no exceptions will be made. You are required to pay your Co-payment at the time of your visit.

If your insurance carrier requires you to have a referral to be seen in our office, you must provide a referral or you will not be seen.
If your insurance requires you to meet an annual deductible before your healthcare is covered you will be billed for the services rendered if you have not met your deductible.

You will be asked to leave a credit card number at the time of check-in. This information will be held securely until your insurances have paid their portion and notified us of your share. At that time, your credit card on file will be charged. You will not receive any prior notification.
Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment.

I _____ (print name) authorize (LACA Dermatology, Inc.)
To charge outstanding balances on my credit card on file.

Card Type: VS __ MC __ AMX __ DSC __ CC #: _____-_____-_____-_____

Exp Date: _____/_____ Security Code: _____
IS THE CARD PROVIDER AN HRA OR FLEX SPENDING ACCOUNT? YES _____ NO _____
Select One:

___ Credit card billing address is the same as current address.

___ Credit card billing address is different from current address.
The correct address associated with the card provided is:

Street Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

I have read the above carefully and acknowledge these terms. I hereby assume all responsibility for any outstanding balances and (is selected) understand that these charges will be applied to the credit card I have provided.

Signature: _____ Date: _____