Dermatology
CONSULTANTS
OF SACRAMENTO

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Thank you for choosing our office for your dermatology services. Enclosed you will find paperwork to be completed before your visit to our office. You may bring this with you at the time of your appointent. In addition to this paperwork, you must also *bring your insurance card* if you wish us to submit a claim for you. Co-pays may be paid in cash, check, or credit card (Visa/MasterCard) at thetime of service.

Please be aware that if your insurance requires a referral to be seen at a specialty office, and you have had a change of coverage or primary care physician, you will need to contact your primary care provider for a new referral prior to your visit with our offic as the original referral will be considered invalid.

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The Providers and Staff of Dermatology Consultants of Sacramento

5340 ELVAS AVENUE, SUITE 600, SACRAMENTO, CA 98519
(916)739-1505 FAX (819)739-1426

PATIENT INFORMATION

NAME _____
Last First MI

ADDRESS _____
Street City State Zip

HOME # _____ MOBILE # _____

OK TO LEAVE VOICEMAIL AT HOME YES ☐ NO ☐ OK TO LEAVE VOICEMAIL ON MOBILE YES ☐ NO ☐

BIRTH DATE _____/_____/_____ AGE _____ GENDER _____ DRIVERS LICENSE # _____

EMAIL ADDRESS _____ SPOUSE NAME _____

PREFERRED PHARMACY _____

EMERGENCY CONTACT _____ PHONE # _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

PHONE # _____ ADDRESS _____

Primary Care Physician _____

IF PATIENT IS A MINOR – COMPLETE THIS SECTION

PARENT/GUARDIAN_____ **PARENT/GUARDIAN** _____

Social Security # _____-_____-_____ Social Security # _____-_____-_____

Employer _____ Employer _____

Employer Phone # _____ Employer Phone # _____

PATIENT'S MEDICAL HISTORY

Has any other family member been seen by our physicians? ☐No ☐Yes If yes, which physician _____

If yes, which relation _____

Reason for today's visit _____

SIGNATURE _____ DATE _____/_____/_____

04/21

Medical History

Name _____ Birth Date _____

Please circle the appropriate answer
Have you been treated for any of the following?

Arthritis	YES ☐	NO ☐
Asthma	YES ☐	NO ☐
Autoimmune disease (e.g. lupus)	YES ☐	NO ☐
Bleeding disorder	YES ☐	NO ☐
Cancer	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐
Hay fever	YES ☐	NO ☐
Heart disease	YES ☐	NO ☐
Hepatitis B or C	YES ☐	NO ☐
High Blood Pressure	YES ☐	NO ☐
HIV Positive	YES ☐	NO ☐
Hives	YES ☐	NO ☐
Keloid or thick scar formation	YES ☐	NO ☐
Kidney disease	YES ☐	NO ☐
Liver disease	YES ☐	NO ☐
Thyroid disease	YES ☐	NO ☐
Tuberculosis	YES ☐	NO ☐

Melanoma	**YES** ☐	**NO** ☐	
Other Skin Cancers	**YES** ☐	**NO** ☐	
Family History of Melanoma	**YES** ☐	**NO**	**If Yes, which relation:** _____

Do you have?

Pacemaker	YES ☐	NO ☐
Artificial Joints	YES ☐	NO ☐
Artificial Heart Valves	YES ☐	NO ☐
Anesthesia allergies or other sensitivities	YES ☐	NO ☐

Have you been hospitalized or had surgery in the last 5 years? YES ☐ NO ☐
If YES, please list: _____

_____

Any other medical conditions that the physician should know about?

_____

What medicines do you take regularly? (Please include over the counter medications, vitamins, herbal products and birth control pills. If you have a list, we will be happy to copy it.)

_____

_____

_____

Any allergies to medicine? YES ☐ NO ☐
If YES, please list: _____

_____

Completed by: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dermatology Consultants of Sacramento may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology Consultants' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dermatology Consultants reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Privacy Officer, Dermatology Consultants of Sacramento, 5340 Elvas Ave, #600, Sacramento, CA 95819.

With my consent, Dermatology Consultants may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With my consent, Dermatology Consultants may mail to my home or other designated location any items that assist carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Dermatology Consultants restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dermatology Consultants of Sacramento's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology Consultant of Sacramento may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Legal Guardian (if applicable)

Protected Health Information Release

Dermatology Consultants of Sacramento's policy is to maintain the confidentiality of your medical records, also referred to as Protected Health Information (PHI). Our office will not disclose personal or medical information about you unless authorized by you or mandated by law.

As a patient, you have the right to determine who may receive medical information about you from our office. Some patients elect no one other than themselves to receive information, while others elect specific family members or friends who may receive their information. In order to assure your PHI continues to be secure, please take a moment to answer the question below.

Please list the first and last name of any individual allowed to receive your Protected Health Information. Please limit to three (3) people. If no one other than you is allowed, please list "self only".

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

Patient's printed name: _____

Patient's signature: _____ Date: _____

If, at any time, you wish to make a change, please ask us for another form. Thank you for your cooperation.

FINANCIAL AGREEMENT
NO SHOW & CANCELLATION POLICY

Thank you for trusting Dermatology Consultants of Sacramento to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. If requested, you will be given a copy of this agreement for your records.

I have received this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I may request and receive a copy of this financial agreement for my records.

Patient Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Insurance
Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

Medicare
We participate in the Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered. We may ask you to sign an Advanced Beneficiary Notice, which lists our fees and notifies you of your financial responsibility for certain medical services. **Managed Care**: Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies, your procedure may not be a covered benefit. It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company. Please contact your insurance company with questions regarding your coverage.

Continued on reverse

Patient Responsibility for Payment
You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your service. Patient due balances noted on your monthly statement are due within 30 days of receipt. Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent. If insurance payment results in a credit balance, it will be refunded to you within 30 days.

Payment Options
We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our business office at (916) 739-1505 to make payment arrangements. **Non-Payment**: Failure to pay will result in your account being referred to a collection agency, which may affect your credit. You must contact our billing office to discuss payment arrangements. NSF checks will result in a $25 processing fee.

No Show & Cancellation Policy
We require notification of cancellation for your appointment **at least one business day in advance**. Early notification helps us to fill the vacated slot in a timely manner. If proper notification is not given, this will be considered a No Show. After 3 No Show appointments, dismissal from the practice may be considered.