EXCEPTIONAL
DERMATOLOGY CARE

Date: _____ / _____ / _____

Patient (Legal) Name: _____ Nickname: _____

SSN (>Age 18): _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Driver's License #: _____ State: _____

Mailing Address: _____

(Street/PO Box, City, State, Zip Code)

Home Address: _____

(Street, City, State, Zip Code)

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Daytime Phone: _____ Home Phone: _____ Cell Phone: _____

E-Mail: _____

Emergency Contact: _____ Phone #: _____

Employment Information

Employer: _____

Occupation: _____

Work Address: _____

Work Phone: _____ E-Mail: _____

Primary Insurance

Name of Primary Insurance Co.: _____ Phone: _____

ID/Policy No.: _____ Group No.: _____

Subscriber/Insured: _____ Relationship: _____ Sex: _____

Date of Birth: _____ SSN: _____

Employer Name: _____ Employer Phone: _____

Secondary Insurance

Name of Primary Insurance Co.: _____ Phone: _____

ID/Policy No.: _____ Group No.: _____

Subscriber/Insured: _____ Relationship: _____ Sex: _____

Date of Birth: _____ SSN: _____

Employer Name: _____ Employer Phone: _____

EXCEPTIONAL
DERMATOLOGY CARE

For Minor Children Only:

"Responsible Party" is the parent/legal guardian who completes this form.

Responsible Party Name: _____ Home Phone: _____

SSN: _____ Date of Birth: _____ Cell Phone: _____

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

Please Sign (For Adults):

I, the undersigned, assign directly to Exceptional Dermatology Care all surgical and/or medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Signature: _____ Date: _____

(If patient is a minor, signature or guardian authorizing treatment)
*NOTE: Please notify us if any of the above information changes during the course of your treatment.

EXCEPTIONAL
DERMATOLOGY CARE

Patient Name: _____ DOB: _____ Date: _____

Staff Initials: _____

SECTION I

What is your ethnicity?

Please check one or more boxes.

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ **Decline to specify**

Please select the racial category or categories with which you most closely identify with.

Check as many as apply.

☐ American Indian or Alaska Native ☐ Black or African American

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ **Decline to specify**

What is your native language?

☐ English ☐ Spanish ☐ **Decline to specify**

Do you require a translator?

☐ Yes ☐ No

SECTION II

Please check the appropriate box if you'd like to receive our monthly emails about specials and VIP events.

☐ Yes ☐ No

How did you *first* hear about the practice? (Please check one)

☐ Magazine, newspaper or other print media. Please specify: _____

☐ Doctor Referral. Name of doctor: _____

☐ Insurance Directory. Please specify: _____

☐ Patient referral. Name of patient: _____

☐ Employee of Exceptional Dermatology Care. Name of employee: _____

☐ Internet. Please check which website you originally found us on:

- ☐ Google ☐ Yahoo ☐ Yelp ☐ Facebook ☐ Instagram
- ☐ Google+
- ☐ Other website. Please specify: _____

☐ Other referral source not listed above. Please specify: _____

☐ Walk-in

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Patient Name: _____ DOB: _____ Date: _____

Staff Initials: _____

MEDICAL CONDITIONS

Please check mark to indicate if you have the following:

- ☐ None
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hyperplasia
- ☐ Cerebrovascular Accident
- ☐ Chronic Obstructive Lung Disease
- ☐ Coronary Arteriosclerosis
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Elevated Blood Pressure
- ☐ End-Stage Renal Disease
- ☐ Epilepsy
- ☐ Gastroesophageal Reflux Disease
- ☐ Hearing Loss
- ☐ Human Immunodeficiency Virus Infection
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Disease of Liver
- ☐ Leukemia
- ☐ Malignant Lymphoma (Clinical)
- ☐ Malignant Tumor of Lung
- ☐ Malignant Tumor of Breast
- ☐ Malignant Tumor of Colon
- ☐ Malignant Tumor of Prostate
- ☐ Radiation Therapy Treatment Management
- ☐ Transplantation of Bone Marrow
- ☐ Other: _____

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DERMATOLOGY CARE

Patient Name: _____ DOB: _____ Date: _____

Primary Care Physician: _____ Staff Initials: _____

PAST SURGERIES

Please check mark if you have had surgeries on the following organs:

- ☐ None
- ☐ Abdominoperineal Resection
- ☐ Bilateral Replacement of Knee Joints
- ☐ Biopsy of Breast
- ☐ Biopsy of Prostate
- ☐ Coronary Artery Bypass Graft
- ☐ Entire Transplanted Kidney
- ☐ Excision of Basal Cell Carcinoma
- ☐ Excision of Melanoma
- ☐ Excision of Squamous Cell Carcinoma
- ☐ H/O: Colostomy
- ☐ H/O: Tubal Ligation
- ☐ History of Appendectomy
- ☐ History of Bilateral Mastectomy
- ☐ History of Cholecystectomy
- ☐ History of Colectomy
- ☐ History of Liver Excision
- ☐ History of Percurtaneous Transluminal Coronary Angioplasty
- ☐ History of Tissue Graft Heart Valve Replacement
- ☐ History of Total Cystectomy
- ☐ History of Transurethral Prostatectomy
- ☐ Hysterectomy
- ☐ Kidney Biopsy
- ☐ Low Anterior Resection of Rectum
- ☐ Lumpectomy of Breast
- ☐ Lumpectomy of Left Breast
- ☐ Lumpectomy of Right Breast
- ☐ Mastectomy of Left Breast
- ☐ Mastectomy of Right Breast
- ☐ Mechanical Heart Valve Replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Percutaneous Extraction of Kidney Stone
- ☐ Portosystemic Shunt Operation
- ☐ Prostatectomy
- ☐ Prosthetic Arthroplasty of Bilateral Hips
- ☐ Splenectomy
- ☐ Surgical Biopsy of Skin
- ☐ Total Nephrectomy
- ☐ Total Orchidectomy
- ☐ Total Replacement of Left Hip Joint
- ☐ Total Replacement of Left Knee Joint
- ☐ Total Replacement of Right Hip Joint
- ☐ Total Replacement of Right Knee Joint
- ☐ Transplantation of Heart
- ☐ Transplantation of Liver
- ☐ Other: _____

EXCEPTIONAL
DERMATOLOGY CARE

Patient Name: _____ DOB: _____ Date: _____

Staff Initials: _____

SKIN CONDITIONS

Have you had any of the following skin conditions:

- ☐ None
- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asteatosis Cutis
- ☐ Basal Cell Carcinoma of Skin
- ☐ Contact Dermatitis Due to Poison Ivy
- ☐ Dysplastic Naevus of Skin
- ☐ Eczema
- ☐ H/O: Asthma
- ☐ H/O: Hay Fever
- ☐ Malignant Melanoma
- ☐ Pruritus of Scalp
- ☐ Psoriasis
- ☐ Squamoue Cell Carcinoma
- ☐ Sunburn of Second Degree
- ☐ Other: _____

Do you wear sunscreen? ☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

FAMILY HISTORY OF MELANOMA

Do you have a family history of Melanoma? ☐ Yes ☐ No

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter

☐ Other: _____

EXCEPTIONAL
DERMATOLOGY CARE

Patient Name: _____ DOB: _____ Date: _____

Staff Initials: _____

MEDICATIONS & ALLERGIES

Please list all medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please list all medications you are allergic to:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

EXCEPTIONAL
DERMATOLOGY CARE

Patient Name: _____ DOB: _____ Date: _____

Staff Initials: _____

SMOKING HABITS

What is your smoking status? (please check one):

☐ Current everyday smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Unspecified

ALCOHOL & DRUG USE

How many times in the past year you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adults older than 65? _____
Do you consume alcohol (EtOH or grain alcohol)? _____
Illicit drug use? ☐ Yes ☐ No

ALCOHOL & DRUG USE

Are you sexually active?

☐ None
☐ Not sexually active
☐ Sexually active with one partner
☐ Sexually active with more than one partner
☐ Same sex partner

DRIVING STATUS

☐ Drive in the Daytime ☐ Drive at Night

EXERCISE STATUS

How often do you exercise? _____

CAFFEINE USAGE

What is your caffeine use? _____

OCCUPATION

What is your occupation and workplace? _____

RESIDENCE STATUS

Do you feel safe at home? ☐ Yes ☐ No

What is your place of residence? _____

EXCEPTIONAL
DERMATOLOGY CARE

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a Patient Rights section describing your patient rights under the law. You have a right to review this Notice before signing this Consent. The terms of the Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for:

- Treatment (including direct and indirect treatment by other healthcare providers involved in your medical care)
- Payment from your insurance company or third party payers
- The day-to-day healthcare operations of our practice

You have the right to revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent is not affected. The practice provides this form to comply with the Health Insurance Probability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operation
- The Practice has a Notice of Privacy Practices, and the Patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The Patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions
- The Patient may revoke this consent in writing at any time
- The Practice may condition receipt of treatment upon execution of this consent

Please provide us the name(s) of family members or other persons, if any, to whom we may release information regarding your general medical condition, financial account, or who have permission to pick up information you have requested.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

☐ Self ☐ Parent ☐ Legal Guardian

EXCEPTIONAL
DERMATOLOGY CARE

Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. If you have health insurance and even if we bill your insurance company directly, you will be responsible for copayment, coinsurance, deductible, and non-covered amounts. For your convenience, our office accepts personal checks, credit cards, and cash, and when appropriate, can provide you with mutually agreed upon payment plan. It's also important to note that all cosmetic treatments are not covered by any health insurance plan and are due at the time of service. Please read the following carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works, insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, and disallow procedure codes, and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" charges in the amount they are willing to cover. The insurance company usually reduces the actual reimbursement further by the individual policy's annual deductible, copayment or coinsurance.

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes that the insurance company will likely reduce, combine, or simply deny. This system in fact, has the insurance company determining our fees. If we have a contract with your insurance company, we write off the amount over the "reasonable and customary", and bill you for your coinsurance and deductible. If we do not have a contract with your insurance carrier, you are responsible for that amount as well as any deductible and coinsurance.

We are required by all insurance carriers to collect from patients any deductible and copayment or coinsurance amounts. These fees can be reduced only in those cases where true financial hardship can be demonstrated. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of Non-Sufficient Funds or your account is turned over to Collections, you will be responsible for all related costs.

I have read and understand Exceptional Dermatology Care's financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Exceptional Dermatology Care.

In the event Exceptional Dermatology Care agrees to seek payment initially from my insurance company, I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize Exceptional Dermatology Care to release all information necessary to secure payment of benefits.

Patient (Legal) Name: _____

Signature: _____ Date: _____

EXCEPTIONAL
DERMATOLOGY CARE

STANDARD PATIENT/PHYSICIAN ARBITRATION AGREEMENT

1. It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuits or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, this arbitration agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2. **ALL CLAIMS BUST BE ARBITRATED.** I understand that all claims for damages arising from medical services rendered by Exceptional Dermatology Care, and/or associate or substitute physicians, nurses or employees must be arbitrated. This includes any claim of a spouse, heir, child (born or unborn), or other succession in interest to any such claim.

3. **ARBITRATION PANEL.** Within 30 days of a demand to arbitrate a dispute, which must be made in writing, the parties shall agree of three medical arbitrators. Each party will bear the costs for their own legal counsel, and other expenses incurred for their own benefit, as well as their pro rata share of arbitration expenses.

4. **APPLICABLE LAW.** I agree that the California Code of Civil Procedure relating to arbitration shall apply without any exception.

5. **REVOCATION OF THE AGREEMENT.** This agreement may be revoked and canceled by written notice delivered to Exceptional Dermatology Care within 30 days of the signing of this agreement. If notice of revocation of this agreement is not received within 30 days of its signing, the right to cancel the agreement is forever waived.

6. **RETROACTIVE EFFECT.** If the signing party intends this agreement to cover all services rendered before the date of the signing of this agreement (including, but not limited to, prior consultations or treatment), the signing party must initial here: _____.

7. **ACKNOWLEDGEMENT.** By signing this agreement, the signing party acknowledges he/she discussed to his/her satisfaction any questions he/she may have had regarding the arbitration agreement with Exceptional Dermatology Care, an associate physician, or authorized legal representative of Exceptional Dermatology Care.

8. If any provision of this arbitration agreement should be held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OF COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Dated: _____

Patient, Parent, Guardian or Authorized Representative: _____

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

Physician's agreement to arbitrate: Inconsideration of the foregoing execution of the Patient Physician Arbitration Agreement, Exceptional Dermatology Care and Staff likewise agree to be bound by the terms set forth in agreement.