Pacific Dermatology
5924 Stoneridge Drive Suite 101 Pleasanton, CA 94588
p 925.426.8828 f 925.428.8812

PATIENT INFORMATION

Name: ______________________________ Age: ________ Date of Birth: ______________
Last First MI
How would you like to be addressed? ______________ SS#: ______________ Sex: M F
Mailing Address: ______________________________
City State Zip
Home: ( )______________ Work: ( )______________ Cell: ( ) ______________
Marital Status: S M W D Email Address: ______________
Occupation: ______________ Your Employer: ______________
Referred By: (please circle one) family member doctor friend yellow pages newspaper
Referring Doctor: ______________ Primary Care Physician (PCP): ______________
Pharmacy: ______________ Pharmacy Telephone #: ______________
Emergency Contact: ______________________________ Phone Number: ______________
Full Name Relationship

Reason for visit / skin problem? ______________________________

INSURANCE INFORMATION

Person Responsible for Account: ______________________________
Last First MI
Relationship to Patient: ______________ Date of Birth: ______________ SS#: ______________
Mailing Address (if different from patient's): ______________________________
Phone Number: Home: ( )______________ Work: ( )______________ Cell: ( )______________
Employer Name: ______________ Employer Phone: ______________
Primary Insurance Name: ______________________________
ID / Subscriber #: ______________ Group #: ______________
Name of other dependents covered under this plan: ______________
Is the patient covered by additional Insurance? Y / N
(If yes) Name of Secondary Insurance: ______________ Insurance ID/Group: ______________
Guarantor: ______________ Relationship to pt: ______________ Date of Birth: ______________

CANCELLATION POLICY

I understand that there is a $25 charge for all missed and cancelled appointments and $50 for cosmetic procedures without 24 business hour notice. ________ (initial)

PRODUCT RETURN POLICY

All returned/exchanged products must be made within 2 weeks and will incur a 10% restocking fee. All sales are final for Jane Iredale Products as well as special/custom ordered products. ________ (initial)

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Dr. Cecile Lee or Dr. Hank Fung all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions whether manual or electronic.

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Responsible Party Signature Relationship to Patient Date

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NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR OTHER HEALTH CARE OPERATIONS

** Do we have your permission to leave messages regarding your medical condition and/or test results on an answering machine ? Y / N Which phone number may we leave messages on? (please circle) home / work / cell / other:________________________

** Do we have your permission to discuss your medical condition with and/or give test results to a member of your household? Y / N Name of family member and relationship: ____

I, _________________________, understand, with this signed consent, that Pacific Dermatology may use and disclose my protected health information to carry out treatment, payment and healthcare operations. I also understand that as part of my health care, Pacific Dermatology originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatments, and any plans for future case or treatments. I understand that this information serves as:

* A basis for planning my care and treatment
* A means of communication among the health professionals who contribute to my care
* A source of information for applying my diagnosis and surgical information to my bill
* A means by which a third-party payer can verify the services billed were actually rendered
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand that I have the right to a hard copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I wish to have the following restrictions to the use or disclosure of my health information: __________________________
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I understand that Pacific Dermatology is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the office has already taken action in reliance there on. I also understand that by refusing to sign this consent or revoking this consent, this office may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Pacific Dermatology reserves the right to change their notice and practices in accordance with Section 164.520 of the Code of Federal Regulations. Should Pacific Dermatology change their notice, a copy of the revised notice will be sent to the address I've provided.

I understand that as part of this office's treatment, payment, or health care operations, it may be necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent.

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Patient/Parent/Guardian Signature | Printed Name | Date