Z DERMATOLOGY
& SKIN WELLNESS CENTER

# NEW PATIENT PAPERWORK

**PATIENT DEMOGRAPHICS:**

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE SSN: _____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RACE: ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN

☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ WHITE ☐OTHER _____

ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC

LANGUAGE SPOKEN AT HOME (IF OTHER THAN ENGLISH): _____

OCCUPATION: _____ EMPLOYER: _____

WORK ADDRESS: _____

**CONTACT:**

HOME: _____ WORK: _____ CELL: _____ EMAIL: _____

*MAY WE LEAVE A DETAILED MESSAGE REGARDING RESULTS?* ☐ YES ☐ NO WHICH NUMBER?_____

*MAY WE EMAIL YOU FOR APPOINTMENT REMINDERS, CONFIDENTIAL RESULTS, PROMOS, ETC.?* ☐ YES ☐ NO

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

**INSURANCE INFORMATION** - GUARANTOR INFORMATION - RESPONSIBLE PARTY

LAST NAME: _____ FIRST NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ SSN: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

INSURED EMPLOYER: _____ INSURED OCCUPATION: _____

**PRIMARY INSURANCE**

INSURANCE NAME: _____

NAME/DOB OF INSURED: _____

MEMBER ID #_____

GROUP # _____

**SECONDARY INSURANCE** (IF APPLICABLE)

INSURANCE NAME:_____

NAME/DOB OF INSURED _____

MEMBER ID # _____

GROUP # _____

**PRIMARY CARED PHYSICIAN:** _____ PHONE: _____ FAX: _____

PCP ADDRESS: _____

**PREFERRED PHARMACY**

PHARMACY NAME: _____ ADDRESS: _____

PHARMACY PHONE: _____ PHARMACY FAX: _____

**EMERGENCY CONTACT**

LAST NAME: _____ FIRST NAME: _____

PHONE NUMBER: _____ RELATIONSHIP TO PATIENT: _____

*MAY WE DISCUSS YOUR HEALTH INFORMATION WITH THIS PERSON?* ☐ YES ☐ NO

WHO REFERRED YOU TO OUR OFFICE? _____

☐ INSURANCE REFERRAL ☐ FACEBOOK ☐INSTAGRAM ☐ YELP ☐ OTHER _____

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## PAST MEDICAL HISTORY

☐ ANXIETY
☐ ARTHRITIS
☐ ASTHMA
☐ ATRIAL FIBRILLATION
☐ BONE MARROW TRANSPLANTATION
☐ BREAST CANCER
☐ COLON CANCER
☐ COPD
☐ HIGH CHOLESTEROL
☐ LEUKEMIA
☐ IMMUNOSUPPRESSION
☐ STROKE
☐ HEART ATTACKS
☐ CORONARY ARTERY DISEASE
☐ DEPRESSION
☐ DIABETES
☐ KIDNEY DISEASE
☐ GERD
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ HIV/AIDS
☐ THYROID DISEASE
☐ LUNG CANCER
☐ IMMUNOSUPPRESSION
☐ SEIZURES
☐ RADIATION TREATMENT
☐ **NONE**
☐ OTHER MEDICAL HISTORY NOT SPECIFIED

_____
_____
_____

## ALERTS

☐ HISTORY OF MRSA
☐ ON BLOOD THINNERS
☐ ANTIBIOTIC FOR DENTAL PROCEDURES
☐ FAINTING WITH PROCEDURES
☐ REACTION TO LIDOCAINE
☐ BLOOD CLOTS
☐ ARTIFICIAL JOINT YEAR: _____
☐ ARTIFICIAL HEART VALVE
☐ RAPID HEARTBEAT WITH EPINEPHRINE
☐ PACEMAKER
☐ DEFRIBRILLATOR
☐ PREGNANT OR TRYING TO GET PREGNANT
☐ KELOID SCARRING
☐ COLD SORES / ORAL HERPES
☐ **NONE**

### CONTACT ALLERGIES

LATEX ALLERGY ☐ YES ☐ **NO**
ADHESIVE ALLERGY ☐ YES ☐ **NO**
TOPICAL ANTIBIOTIC ALLERGY ☐ YES ☐ **NO**

**PAST SURGICAL HISTORY:** (PLEASE LIST SURGERY AND YEAR) ☐ **NONE**

_____
_____

**ALLERGIES:** (PLEASE LIST ALL ALLERGIES) ☐ **NONE**

_____
_____

**SKIN DISEASE HISTORY (SELF):** ☐ **NONE**

☐ ACNE
☐ ACTINIC KERATOSIS
☐ BASAL CELL CARCINOMA
☐ BLISTERING SUN BURNS
☐ FLAKING/ITCHY SCALP
☐ HAY FEVER/ ALLERGIES
☐ PRECANCEROUS MOLES
☐ ECZEMA
☐ ROSACEA
☐ SQUAMOUS CELL CARCINOMA
☐ MELANOMA (YEAR/STAGE): _____
☐ PSORIASIS
☐ OTHER: _____

WEAR DAILY SUNSCREEN? ☐ YES ☐ NO SPF: _____

HISTORY OF TANNING BED USE: ☐ YES ☐ NO IF YES, HOW OFTEN?_____

FAMILY HISTORY OF FIRST DEGREE RELATIVE WITH MELANOMA? ☐ YES ☐ NO IF YES, WHO? _____

ALCOHOL INTAKE: ☐ NEVER DRINK ☐ 1-2 DRINKS/MONTH ☐ 1-2 DRINKS/WEEK ☐ DRINK DAILY

SMOKING STATUS: ☐ NEVER SMOKED ☐ CURRENT SMOKER ☐ FORMER SMOKER

IF YOU ARE A SMOKER, WOULD YOU LIKE HELP QUITTING? ☐ YES ☐ NO

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**REASON FOR TODAY'S VISIT (CHIEF COMPLAINT):** _____

WHAT PART OF THE BODY IS AFFECTED: _____ SYMPTOMS: _____

HOW SEVERE IS THIS PROBLEM? ☐ MILD ☐ MODERATE ☐ SEVERE ☐ N/A

HOW LONG HAVE YOU HAD THIS PROBLEM? _____ DAYS _____ WEEKS _____ MONTHS _____ YEARS

WHAT TREATMENT HAVE YOU RECEIVED FOR THIS PROBLEM? _____

IS YOUR PROBLEM (PLEASE CHECK ONE OF THE FOLLOWING): ☐ WORSENING ☐ STABLE ☐IMPROVING

PERTINENT HISTORY

☐ BASAL CELL SKIN CANCER ☐ SQUAMOUS CELL SKIN CANCER ☐ MELANOMA

☐ FAMILY HISTORY OF MELANOMA ☐ FAMILY HISTORY OF BCC OR SCC ☐ DYSPLASTIC NEVI

**REVIEW OF SYSTEMS:** ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

| | | | |
|---|---|---|---|
| ☐ PROBLEMS WITH BLEEDING | ☐ UNINTENTIONAL WEIGHT LOSS | ☐ CHEST PAIN | ☐ IMMUNOSUPPRESION |
| ☐ FREQUENT INFECTIONS | ☐ THYROID PROBLEMS | ☐ PALPITATIONS/IRREGULAR | ☐ SORE THROAT |
| ☐ PROBLEMS WITH SCARRING | ☐ MOUTH SORES | HEARTBEATS | ☐ MOUTH ULCERS |
| ☐ PROBLEMS WITH HEALING | ☐ ABDOMINAL PAIN | ☐ FEVERS/CHILLS | ☐ HEADACHES |
| ☐ RASH | ☐ BLOODY STOOL | ☐ NIGHT SWEATS | ☐ SEIZURES |
| ☐ SENSITIVITY TO LIGHT | ☐ BLOOD IN URINE | ☐ COUGH | ☐ DIZZINESS |
| ☐ ITCHING/BURNING OF SKIN | ☐ MUSCLE WEAKNESS | ☐ SHORTNESS OF BREATH | ☐ MEMORY LOSS |
| ☐ NUMBNESS | ☐ JOINT PAIN | ☐ WHEEZING | ☐ DEPRESSION |
| ☐ HAY FEVER | ☐ NECK STIFFNESS | ☐ ANXIETY | ☐ CONSTIPATION |
| ☐ NAUSEA | ☐ VOMITING | ☐ DIARRHEA | ☐ **NONE** |

**MEDICATIONS** (PLEASE LIST ALL MEDICATIONS) – ***ADD DOSAGE/FREQUENCY***

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

*I hereby certify that information written on this intake form is complete and accurate. I understand that omission of relevant medical history may compromise the quality of patient care and patient outcome.*

Patient/Guardian signature: _____ Date: _____

18800 Main St., Suite 111 Huntington Beach, CA 92648
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# FINANCIAL POLICY & CONSENT

Payment is required for all services at the time they are rendered unless you have an insurance plan with which we participate. Applicable co-payments, co-insurances, and deductibles will be collected at the time of your visit. Private insurance billing will be performed as a courtesy to our patients. Additional tests run either in the office or at an outside facility, (i.e. pathology, laboratory, radiologic or other diagnostic tests) may be billed separately in addition to the office visit. Payment is required at time of service for all cosmetic procedures. For your convenience, we accept cash, checks, Visa, MasterCard, and Discover. At your request, a copy of this document can be made available to you.

Regardless of insurance coverage, verification of benefits, or contracts with insurance, THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYING for the services rendered. This contract is between you, the patient, and Z Dermatology & Skin Wellness Center. Claims that are denied for lack of authorization/coverage/eligibility, or lack of medical necessity as determined by your insurance or out-of-network benefits will be the responsibility of the patient. It is the patient's responsibility of notifying the office of changes in insurance eligibility or coverage.

## Credit Card on File Policy

I agree to Z Dermatology & Skin Wellness Center's Credit Card on File Policy, which requires all patients to have a valid credit card on file with Z Dermatology & Skin Wellness Center. Credit cards are stored securely in a Payment Card Industry (PCI) compliant payment gateway. By signing this document, I authorize Z Dermatology & Skin Wellness Center to automatically charge my card for any outstanding balance with Z Dermatology & Skin Wellness Center. Prior to charging my credit card, Z Dermatology & Skin Wellness Center will send me ONE invoice via email with details about my balance and an option to make a payment. I will have two (2) weeks after this invoice to pay the invoice online or ask any questions, before the credit card on file will be charged. I understand that the credit card on file with Z Dermatology & Skin can be changed at any time upon my request.

**Cancellation Policy**: If you need to cancel or reschedule your appointment, we need to know at least one (1) full business day before your regular appointment or two (2) full business days before your surgical or cosmetic appointment. For example, if you have to cancel a regular appointment on Monday at 9 am, we need to know by the previous Friday before 9 am. This allows us to offer the appointment to another patient. A $50 charge will be assessed for no-shows or cancellations with less than 1 full business day notice for regular clinic appointments, and $100 charge for any surgical or cosmetic appointments with less than 2 full business days notice**.** Our ability to meet the needs of patients is compromised by individuals who regularly fail to keep their appointments or reschedule with high frequency. Patients no-showing or canceling three (3) times without notice will be considered for dismissal from the practice. Returned Checks: The charge for a returned check is $25. This will be applied to your account in addition to the insufficient funds amount.

Your signature below signifies (1) your understanding and agreement to the above policies, and your responsibility to pay for all applicable fees on the day of service and any balances not covered by insurance. (2) Authorizes the release any information, including the records of all visits provided at Z Dermatology & Skin Wellness Center, for the purpose of processing your claims to insurance. (3) Authorizes your insurance company to assign benefits directly to Dr. Teresa Zamary or her associates, the amount due in your pending claim. (4) Complied with our "Credit Card on File" financial policy listed above. (5) you understand that emails will be sent with your invoice.

*Your signature also authorizes the payment of insurance benefits to be made on your behalf to Z Dermatology & Skin Wellness Center or Dr. Teresa Zamary for services furnished to you by Dr. Zamary and her staff. Your signature authorizes medical information about you needed to determine these benefits to be released to insurance, CMS and/or its agents. Co-insurance and deductibles are based on the determination of your insurance.*

**Patient/Guardian Signature:** _____ **Date:** _____

**Patient/Guardian Name (print):** _____

**EMAIL ADDRESS** (for billing purposes): _____

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**HIPAA Consent**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

- Treatment: This includes the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
- For payment: This includes any activities we must undertake in order to get reimbursed for the services provided to our patients, including such things as organizing PHI and submitting bills to insurance companies ( either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.
- For health care operations: This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising and certain marketing activities.

I have been informed of and offered a copy of the Notice of Privacy Practices for Z Dermatology & Skin Wellness Center containing a more complete description of the uses and disclosures of my health information. I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge a clear understanding of the Privacy Practices. I understand that Z Dermatology & Skin Wellness Center has the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to protected health information (PHI) that has been maintained by Z Dermatology & Skin Wellness Center. Any material changes to the Notice will be promptly posted in the office or on the Z Dermatology & Skin Wellness Center website. I will be given a copy of the latest version of this Notice at my next visit or I can contact Z Dermatology & Skin Wellness Center at the address above.

I understand that I may request in writing that Z Dermatology & Skin Wellness Center restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. However, if the information is needed to provide emergency treatment, then Z Dermatology & Skin Wellness Center may use or disclose my PHI to a healthcare provider to provide me with emergency treatment. I understand that I may restrict the right to disclose my PHI to a health plan for payment if I pay in full for the services and items provided at the time of the visit.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has already taken action relying on this consent.

*Do you give us permission to discuss your medical record with anyone? (Specify name, Date of Birth, & relationship):

1:

2:

3:

**[ ]** DO NOT SHARE MY INFORMATION WITH ANYONE ELSE

May we leave detailed information regarding your health information on your answering machine, voicemail, and/or e-mail? Yes / No

**Patient/Guardian Signature:** _____ **Date:** _____

**Patient/Guardian Name (print):** _____

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## Consent for Evaluation, Examination, and Treatment

By signing below, I authorize the evaluation, examination, and treatment by Dr. Zamary and her staff. Consent to treatment necessary for my dermatological care. Skin growths may be treated by freezing, injections, snip removal, extractions, application of a topical or intralesional medication, and/or electrocautery with a heated needle. A skin biopsy (taking a small sample of skin under local anesthesia) may be used for diagnosis. *I understand I can refuse any procedure.*

I understand that there are risks to any procedure, including, but are not limited to:

- Allergic reaction
- Bleeding
- Pain
- Infection
- Scarring or skin discoloration (lighter or darker)
- Nerve injury (rare)
- Lesion recurrence
- Wound dehiscence

I consent to having these procedures done as part of my evaluation and treatment.

By my signature below, I also understand the following:

- Full body skin exams (FBSE) for skin cancer screening are performed if specifically scheduled in advance or if time permits, as this requires additional time. I understand that my insurance may not cover a FBSE more frequently that what is medically indicated.
- I understand that most clinic visits are scheduled for consultation of a specific skin condition. Procedures, even minor removals, may need to be scheduled at a separate time. Z Dermatology & Skin Wellness Center will try to accommodate procedures if time permits. I understand that some insurance policies will require prior authorization for procedures, which will be done at a later visit.
- I am aware that there are potential risks to any treatment or medication (oral or topical) prescribed. Dermatological conditions are often chronic in nature and may require ongoing care and the need for me to schedule follow up appointments.
- I understand that all tissue removed is sent to a pathology lab for analysis. Removals will not be performed without tissue analysis. The pathology lab will charge a fee for tissue analysis separate and independent of the procedure charge. In your insurance company does not cover this charge, it is the responsibility of the patient or guardian to cover this expense.
- I understand that ANY PROCEDURE including but not limited to freezing/cryosurgery, application of topical or intralesional medication, biopsy, surgical excision, drainage of abscess, wart removal, etc. will be a procedural charge applied to my deductible. I may request cost prior to completion.

  **____ (Initials)** Consent for Treatment: I authorize Z Dermatology & Skin Wellness Center providers to provide any healthcare services that my provider deems necessary for treatment and/or diagnosis including biopsies. I also understand that in the course of that treatment, photographs may be taken for clinical purposes. If photographs will be used for commercial or educational purposes, I will be provided an additional authorization. No videotaping or photography is allowed by non-staff members.

  **____ (Initials)** Consent for Filing Insurance Claims: I understand that, in order to file claims and release medical information to any insurance company(s) I have listed in my financial record Z Dermatology & Skin Wellness Center. Is required to keep my signature on file. I hereby authorize Z Dermatology & Skin Wellness Center to receive benefits directly from my insurance company when an assigned claim is filed. I also authorize Z Dermatology & Skin Wellness Center to appeal any denial to my insurance company on my behalf and authorize the release of any medical information to my insurance company(s) that is necessary for the processing of claims.

  **____ (Initials)** Consent for Appointment Reminders: I understand that Z Dermatology & Skin Wellness Center will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I further understand that I will have the option to opt out of future text/email reminders.

  **____ (Initials)** I have been offered a copy of the Notice of Privacy Policies for Z Dermatology & Skin Wellness Center.

  **____ (Initials)** This authorization and consent shall remain in force for this and all future visits at Z Dermatology & Skin Wellness Center.

**Patient/Guardian Signature:** _____ **Date:** _____

**Patient/Guardian Name (print):** _____

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# PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** 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 lawsuit 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, 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.

Article 2: **All Claims Must Be Arbitrated**: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against Physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

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

By: _____
Physician's or Duly Authorized Representative Signature (Date)

By _____
Print or Stamp Name of Physician, Medical Group or Association Name

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

By: _____
Patient's Representative's Signature (if applicable)(Date)

_____
Print Name and Relationship to Patient

A signed copy of this document should be given to the patient. The original copy will be archived in the patient's medical file.