NEWPORT BEACH
DERMATOLOGY &
PLASTIC SURGERY

PATIENT INFORMATION

Name:_____ **Date of Birth:** _____
Last *First* *M.I* *MM/DD/YYYY*

Mailing Address:_____
Street Address *City* *State* *Zip*

Cell Phone: _____ **Home Phone:**_____

Email Address:_____

Birth Sex: ❒ Female ❒ Male **Preferred Pronouns**: ❒ He/Him ❒ She/Her ❒ They/ Them ❒ Other_____

Height :_____ **Weight:**_____

If patient is a minor:_____ _____ _____
Parent/Guardian Name *Relationship to Patient* *Parent/Guardian Date of Birth*

Emergency/Health Contact is a person whom we can discuss the patient's care/emergencies/finances in detail:

_____ _____ _____
Emergency/Health Contact Name *Relationship to Patient* *Phone Number*

_____ _____ _____
Emergency/Health Contact Name *Relationship to Patient* *Phone Number*

I consent to sharing the following information with the above people until revoked in writing ❒ Yes ❒ No
If yes, please check what information we may share:
❒ Billing information ❒ Lab/Pathology Results ❒ Appointment Information

Pharmacy Name & Location:_____ _____
Pharmacy Name *Pharmacy Address*

INSURANCE INFORMATION
Patient's Insurance Information: ❒ **Or, Check Here if Self-Pay** (e.g., no insurance, HMO Benefits only, Kaiser, Medi-Cal etc.)

Primary Insurance Co:_____ **Subscriber Number/ID:**_____

_____ _____ _____
*Insurance Subscriber Name (if **not** the patient)* *Relationship to Patient* *Subscriber Date of Birth*

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MEDICAL QUESTIONNAIRE

Reason for Visit:_____

_____

Please list any medications, herbal supplements and/or vitamins you are taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? ❒ Yes ❒ No *(if yes, please list medication and reaction)*

Medication:_____ Reaction:_____

Medication:_____ Reaction:_____

Please list major surgeries:

_____ Date:_____ _____ Date:_____

_____ Date:_____ _____ Date:_____

Please list any current medical problems: ❒ None

_____

Do you have a history of skin cancer? ❒ No ❒ Yes *(If yes, was it Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma, or other?)*

Please indicate below and list locations and year treated to the best of your ability:

Location:_____Type:_____Year:_____

Location:_____Type:_____Year:_____

Do you have a family history of Melanoma in a first-degree relative? ❒ No ❒ Yes ❒ Unsure

❒ Mother ❒ Father ❒ Siblings

Do you have a history of Atypical Nevi (Atypical Moles) or Actinic Keratosis? ❒ No ❒ Yes ❒ Unsure

Do you have a history of blistering sunburns in childhood? ❒ No ❒ Yes ❒ Unsure

Do you have a history of keloid scars? ❒ No ❒ Yes ❒ Unsure

Do you smoke? ❒ Never ❒ Current smoker ❒ Former smoker*(how long since you last smoked?* _____

TREATMENT CONSENT

_____
Initial

I GIVE MY CONSENT FOR EXAMINATION AND TREATMENT. The nature of many, if not most, dermatology and/or plastic surgery consultations is that an unclothed skin and body examination is indicated. Often another NBDPS staff member may be present, in general this is for both the patient and provider's protection and to assist in the patient's care. I give my consent for examination with or without another NBDPS staff member present, and treatment including biopsies, destructions, lasers, excisions and injections, as discussed with my provider.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____
Initial

Effective date 1/18/2010: I acknowledge that I will receive a copy of the "Notice of Privacy Practices" upon request. If there is any amended "Notice of Privacy Practices," they will be available upon request at my next appointment.

_____
Initial

I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING PROTECTED HEALTH INFORMATION UNDER HIPAA (THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party providers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications. I have been given the right to review your Notice of Privacy Practices prior to signing this acknowledgement. I understand that NBDPS has the right to change its Notice of Privacy Practices and that I may contact the organizations at any time to obtain a current copy. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you agree, then you are bound to abide by such restrictions.

DIGITAL PHOTO CONSENT

Federal law guarantees a patient's right to maintain privacy of medical information. Photographs taken before, during, and after medical procedures may be considered part of the medical information. Please note that the release of all photographs, videos, illustrations, or otherwise is addressed at the

time of taking your photographs for medical records kept with Newport Beach Dermatology & Plastic Surgery. **Please check which use you are authorizing us to have:**

☐ **Any and All Use:** This includes, but is not limited to: advertising, publicity or promotion in print, visual, or electronic media; communications to physicians; publication in medical journals and/or textbook for physician education; and for use in physician lectures and patient education

☐ **Limited Media Use:** This included use as educational photo book material for new patient consultations. Internal use for research development and quality control; communications to physicians.

☐ **Medical Record:** This will limit use of any digital content produced of me to Newport Beach Dermatology & Plastic Surgery, Anne Marie McNeill, MD, PhD Inc., Christopher Ellstrom MD, APC, as well as involved office staff.

OUR FINANCIAL POLICY FOR ALL PATIENTS

_____ *Initial*

At this time, in general, payment is required for all services at the time they are rendered. We do require "credit card on file" (see following for CCOF agreement policy) for all patients in order to hold appointment times/ bill for missed appointments, and collect balances remaining after insurance. If you are in an insurance plan that we participate in, in general, we will bill insurance for you as a courtesy. However, we do reserve the right to collect full payment from the patient for any procedures performed. The patient is responsible for any/all charges not paid by any insurance company. You will receive a notification to your patient portal after any payments are made by your insurance company, indicating any remaining balance. Balance is payable immediately. I agree to make full prompt payment to Anne Marie McNeill MD PhD Inc or Christopher Ellstrom, MD, APC, when billed for any and all charges not covered or paid by insurance. If payment is not made, your CCOF will be billed. I authorize payment directly to the provider for medical insurance benefits payable to me under the terms of my policy. We do reserve the right to change our financial policy at any time. I have read and understand the financial policy statement.

NO SHOW / LATE CANCELLATION POLICY

_____ *Initial*

All appointments (in person and virtual) must be canceled via phone, email, voicemail, or in response to an appointment reminder at least 48 hours prior to your appointment, or your account will automatically incur a no show/late cancellation fee. By signing our CCOF Agreement Policy, you authorize us to charge this fee to the card on file. Below is a list of fee amounts based on appointment type:

Office Visit: $50

Any appointment/procedure scheduled for 30 mins or more: $250

AGREEMENT: I have read each policy, I understand them, and agree.

× _____ _____

*Signature of Patient (**or parent/guardian**)* *Date*

_____ _____

*Printed Name of Patient (**or parent/guardian**)* *Date*

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CREDIT CARD ON FILE AGREEMENT POLICY

Copays are due at the time of service. At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card. You have the ability to dispute a charge or question your insurance company's determination of payment. By signing below, I authorize NBDPS to keep my signature and my credit card information securely on-file in my account. I authorize NBDPS to charge my credit card for any outstanding balances when due. If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give NBDPS a new, valid credit card which I will allow them to charge over the telephone. Even though NBDPS is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

If you prefer to not write the credit card information here on paper, you can present the card to our receptionist and it can be directly stored in our secure digital system.

Name on Card: _____
(Print)

Billing Address: _____
Street Address *City* *State* *Zip*

Credit Card Number: _____ _____ _____
Expiration Date *Security Code*

❒ Please check this box if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance

Signature: x _____ Date: _____

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