.the derm studio.

NEW PATIENT REGISTRATION FORM

____
Date

First Name ______________ MI ______________ Last Name ______________

Address ______________ City ______________ State ______________ Zip code ______________

Home Phone ______________ Cell Phone ______________ Date of Birth ______________ Age ______

Email ______________________________ Referred By ______________________________

Social Security Number ______________________ **Sex:** M F **Marital Status:** M S D W

Emergency Contact Name:______________________________ Phone:____________________

With whom may we share your medical information?________________________________

May we leave a message at your home/cell number? YES NO

What is the best phone number to call you with results? ________________________

Is it ok to leave a voicemail message with **lab results** (your private medical information) on this number? **YES** **NO**

Pharmacy Name:____

Pharmacy Phone Number:____

Pharmacy Address:____

♦♦

Drug Allergies:

____

Medical Illness:

____

Family History of Illness:

____

Medications Currently Taking:

____

FOR OFFICE USE ONLY
History:
BCC______________________
SCC______________________
AK______________________
MM______________________

♦♦

1617 Westcliff Drive, Suite 214 ♦ Newport Beach, CA 92660
Tel: (949) 945-2373♦ Fax: (949) 945-2374

Complete this section if someone other than the patient is financially responsible.

_______________________________ _______________________
Responsible Party Name Relationship to Patient

____
Address City State Zip code

_____________________ _____________________ _______________ ______
Home Phone Cell Phone Date of Birth Age

____
Social Security Number

____ ____________________________________
Employer Work Phone Number

____
Address City State Zip code

♦♦♦

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for any deductibles, co-pays and non covered service amounts.

____ ____________________________
Signature of Patient or Responsible Party Date

I authorize the release of any medical information necessary to process my claim.

____ ____________________________
Signature of Patient of Responsible Party Date

I authorize the payment of medical and surgical benefits to:
Kristen Forman, M.D. INC.

____ ____________________________
Signature of Patient or Responsible Party Date

.the derm studio.

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment and health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health services.

Uses and Disclosures of Protected Health Information: Your Protected Health Information may be used and disclosed by your Physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by your name in the waiting room when your physician is ready to see you. We may disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners: Funeral Directors, and Organ Donation: Research, Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: required Uses and Disclosures: Under the law, We must make disclosures to you and when required by the Security of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes: information complied in reasonable anticipation of, or use in, a civil, criminal or a administration action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclose of your protected health information, your protected health information will not be restricted. You then have the right to pursue another healthcare Professional.

You have the right to request confidential communication from us by alternative means or at an alternative location: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to have your physician amend your protected health information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information:

We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us as or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

You are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by telephone at our main telephone number (949)945-2373. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____
Patient Name Date

_____ _____
Patient Signature Date

_____ _____
Witness Date

.the derm studio.

Financial Responsibility Agreement

I have chosen to receive services from Dr. Kristen Forman/ Dr. Samreen Choudhry/ Holly Beardsley PA-C/ Amber Young PA-C.

If I am using insurance, I understand that my benefits may not be verified at this time. It is my responsibility to know my benefits. Out of courtesy, The Derm Studio staff will attempt to verify benefits.

I understand I am responsible for all deductibles, co-payments and non-covered expenses. If we are not an in-network provider, then I understand out-ofnetwork expenses are my responsibility. I am also aware that any outside services (i.e. lab, biopsies sent to pathology) ordered by the physician are also my financial responsibility depending on my individual insurance carrier.

If I am a cash-paying patient, I am responsible for all charges incurred by The Derm Studio as well as additional charges incurred with outside services (i.e. lab, biopsies sent to pathology) ordered by the provider. I will receive a separate bill from the lab or pathologist for these charges.

_____ _____

Patient Name Date

_____

Patient Signature

1617 Westcliff Drive, Suite 214 ♦ Newport Beach, CA 92660
Tel: (949) 945-2373♦ Fax: (949) 945-2374

.the derm studio.

24 Hour Cancellation and "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, The Derm Studio reserves the right to charge a fee of $50.00-$100.00 (depending on the length of appointment) for all missed appointments which are not cancelled with at least 24hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment.

Thank you for your understanding and cooperation.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____ _____

Print Name Date

_____

Signature

1617 Westcliff Drive, Suite 214 ♦ Newport Beach, CA 92660
Tel: (949) 945-2373♦ Fax: (949) 945-2374

____.the derm studio.____

Patient Consent for Medical Photography

Patient Name: _____
Date: _____

I consent for medical photographs to be taken of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical records, or to demonstrate teaching points to other patients or public through electronic publishing. I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

Choose One Option

1. I consent for my photographs to be used for medical records and in electronic publications. I understand that the image may be seen by members of the general public. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me.

☐ check here if you agree to the above option, but only provided that no identifying information be revealed (i.e. no photos of face)

_____(Signature) _____(Witness)

2. I agree to use of my image for medical records ONLY:

_____(Signature) _____(Witness)

1617 Westcliff Drive, Suite 214 ♦ Newport Beach, CA 92660
Tel: (949) 945-2373♦ Fax: (949) 945-2374