PURE DERMATOLOGY
COSMETIC & HAIR CENTER

Name (Last, First, MI): _____❑ Jr ❑ Sr

Date of Birth: _____ Sex: ❑M ❑ F ❑ Married ❑Divorced ❑ Single ❑ Widowed

Address: _____ Apt. # _____

City: _____ **State:** _____ **Zip Code:** _____

Email: _____

Address: _____

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

Primary Care Physician: _____ **Telephone**: _____
Primary Care Physician Address: _____

How did you hear about our office? Check or explain:

❑ Dr. _____ ❑Insurance Plan:_____
❑ Family/Friend: _____ ❑ Hospital: _____
❑Instagram ❑ Google ❑ Yelp ❑Other (Please specify): _____

Insurance Information -- Guarantor Information -- ❑ Check here if same as patient
Responsible Party: _____ Group #:_____Member ID:_____
Address: _____ State: _____ Zip Code: _____
Last four of Social Security #: _____

Employment
Occupation: _____
Employer Name: _____ Address: _____

Emergency Contact
Name: _____ Relationship to Patient: _____
Phone Number: _____

Financial and Billing Policies

Thank you for choosing Pure Dermatology Cosmetic & Hair Center. We are committed to providing excellent skin health care in a patient focused environment. We are contracted with several insurance plans and will directly bill your insurance under these plans. We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments, deductibles, and other provisions. If you have any questions, we encourage you to call your health plan's member services department. Their number should be listed on the back of your insurance card. We will submit claims to your insurance company. Because of this, we make a copy of your insurance card at every visit. We also ask that you inform us if your insurance information changes. The lack of current information may cause delays in care and make you personally responsible for the cost of the entire visit. If your office visit precedes the effective date of your insurance coverage or is not covered by your insurance, you will be held responsible for all fees incurred as a result of your visit.

Co-payments, Deductibles, and Co-Insurance

Co-payments are due at the time of your office visit. Under the terms of our contract with various insurance plans, we cannot waive any co-payments, deductibles, or co-insurance amounts defined as patient responsibility. If you have any questions regarding your copayments or deductibles, please call your insurance company. For your convenience, we accept cash, checks, and all major credit cards. Payment is required for all services at the time they are rendered. If you are in an insurance plan that we participate in, in general, only applicable copayments and deductibles will be collected at the time of the service and we 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 including third party laboratories or pathologists. I agree to make in full prompt payment to Pure Dermatology when billed for any/all charges not covered. Further, 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.

Assignment of Payment

I hereby authorize payment directly to Pure Dermatology of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

Outside Services

To provide the best care possible, Pure Dermatology Cosmetic & Hair Center may send specimens to an outside source for processing. Examples of these services are pathology and laboratory testing. If we send specimens to an outside office, you will receive a separate billing statement from the outside pathologist or laboratory. These charges will be in addition to those services rendered by Pure Dermatology.

Treatment Consent

The nature of many if not most dermatology and/or cosmetic consultations is that unclothed skin and body examination is indicated. Often another Pure Dermatology 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 Pure Dermatology staff member present, and treatment including biopsies and excision and injections, as discussed with my provider.

Late Charges and Other Fees

Accounts with balances over 90 days old are subject to late fees
Accounts referred to a collection agency may be subject to a $100.00 collection fee, attorney fees, and/or the percentage allowed under California state law.
There is a $25.00 fee for all checks returned for NSF (non-sufficient funds).

Office Visits/PDT

If you are unable to keep your general dermatology, follow-up, or cosmetic appointment , we ask that you notify our office by phone at least 48 hours in advance. We often have patients who can be scheduled in your appointment slot if you notify us of the cancellation with sufficient time. If your cancellation is within 48 hours of your appointment, you may be charged a $100.00 missed appointment/late cancellation fee. If you continue to miss appointments, you may be dismissed from this practice.

Surgical Procedures

If you are scheduled for any surgical procedure, please note, we require at least 72 hours notice to either cancel or reschedule your procedure so that we may accommodate another patient in your appointment slot. A notice less than 72 hours will result in a $250.00 late cancellation fee.

Health Exchange Information

To our patients, this notice describes who health information about you (as a patient of Pure Dermatology) may be used, disclosed, and how you can obtain access to your health information. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPAA). Pure Dermatology is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following information:

The following circumstances may require us to use or disclose your health information:

1. To public health authorities & health oversight agencies that are authorized by law to collect info.
2. Lawsuits and similar proceedings in response to a court of administrative order
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to the health & safety of another individual or the public.
5. These disclosures would only be made with persons or organizations who are able to help prevent such a threat.
6. If you are a member of the U.S. or foreign military (including veterans) and if required by the appropriate authorities.
7. To federal officials for intelligence and national security activities authorized by law.
8. To correctional institutions or law enforcement if you are an inmate or under the custody of a law enforcement official.
9. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications: You can request that Pure Dermatology communicate with you about your health & related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate all reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required by law to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient & medical/billing records, but not including psychotherapy notes. You must submit your request in writing to Pure Dermatology or contact the office for further information.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing & submitted to Pure Dermatology, or contact the office for further information. You must provide us with a reason that supports your request for amendment.
5. Right to copy of this notice: You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy at any time. To obtain a copy of this notice, contact our office.
6. Right to file a complaint: If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office for further information.
7. Right to provide an authorization for other uses and disclosures: Pure Dermatology will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If you have any questions regarding this notice or our health information privacy policies, please contact Pure Dermatology.

Notice of Privacy Practices

I authorize employees from Pure Dermatology to leave me a voicemail with Protected Health Information
Pure Dermatology employees may leave me a voicemail with Protected Health Information to the following number:
_____

Please identify any individual(s) with whom Pure Dermatology employees may discuss your medical condition and/or financial information (optional)

Name: _____ Relationship: _____ Phone: _____

Hoag Health Information Exchange (HIE)

We participate with HIE. HIE is an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law that protects your privacy. If you choose to opt out of the HIE, we will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to the HIE. To opt out of the HIE, please contact the Hoag Director of HIE by phone at 949-764-8722. I hereby acknowledge that I have been presented with a copy of Pure Dermatology Privacy Practices.

I have read, understand, and agree to the above Financial and Billing Policies both medically and cosmetically.
I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles are my responsibility.
I authorize my insurance benefits to be paid directly to Pure Dermatology Cosmetic & Hair Center.
I authorize Pure Dermatology to release pertinent medical information to my insurance company when requested or when needed to obtain authorization for a procedure or to facilitate the payment of a claim. I have given complete and accurate information and agree to inform Pure Dermatology of any changes regarding my personal billing information or my insurance billing information.

PRINT NAME: _____

PATIENT SIGNATURE:_____ **DATE:** _____

Reason for today's visit (chief complaint):

Medical Reason: _____ Cosmetic Reason: _____

What parts of your body are affected?: _____

How does this problem bother you? (symptoms): _____

How severe is your problem ? ☐ Mild ☐ Moderate ☐ Severe ☐ Not Applicable

How long have you had this problem?: _____Years ____Months ____Weeks ____Days

What treatments have you received for this problem?: _____

Is your problem (please check one of the following): ◯ Worsening ◯ Stable ◯ Improving

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Skin Disease History (Please check all that apply)

- ❑ Acne
- ❑ Actinic Keratosis
- ❑ Asthma
- ❑ Melanoma
- ❑ Squamous Cell
- ❑ Psoriasis
- ❑ Basal Cell Skin Cancer
- ❑ Atypical Moles
- ❑ Eczema
- ❑ Precancerous Moles

Family History of Skin Cancers:

- ❑ Dysplastic Nevi
- ❑ Basal Cell Carcinoma
- ❑ Squamous Cell
- ❑ Melanoma
- ❑ If yes, which relatives:_____
- ❑ **NONE**

OTHER:_____

Past Medical History (Please check all that apply)

- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Bone Marrow Transplantation
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ High Cholesterol
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV / AIDS
- ❑ Thyroid Problems
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ **NONE**
- ❑ **OTHER:**_____

Past Surgical History (Please check all that apply)

- ❑ Breast Implants
- ❑ Mechanical Valve Replacement
- ❑ Heart Transplant
- ❑ Prostate Biopsy
- ❑ Prostate Removed: Prostate Cancer
- ❑ Hysterectomy: Fibroids
- ❑ Hysterectomy: Uterine Cancer
- ❑ Joint Replacement, Knee (Right, Left, Bilateral)
- ❑ Joint Replacement, Hip (Right, Left, Bilateral)
- ❑ Joint Replacement within last 2 years
- ❑ Kidney Stone Removal
- ❑ Kidney Transplant
- ❑ Ovaries Removed: Endometriosis
- ❑ Ovaries Removed: Ovarian Cancer
- ❑ **NONE**
- ❑ **OTHER:**_____

Any Surgical Scars? ❑ YES ❑ NO Please confirm the location? _____

***Preferred Pharmacy:**_____
Pharmacy Address:_____**Pharmacy Phone #:**_____
Medications: _____
Allergies: _____
**Branded Medications will be sent to a specialty pharmacy to save you on cost*

Social History (Please check all that apply)

Please confirm your smoking status: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

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Review of Systems: Are you currently experiencing any of the following?

❑	Problems with bleeding	❑	Sore Throat	❑	Cough
❑	Frequent infections	❑	Mouth Ulcers	❑	Shortness of Breath
❑	Problems with healing	❑	Ringing in Ears	❑	Coughing up Blood
❑	Problems with scarring (hype	❑	Blurry Vision	❑	Anxiety
❑	Rash	❑	Abdominal Pain	❑	Depression
❑	Immunosuppression	❑	Bloody Stool	❑	Dizziness
❑	Hay Fever	❑	Bloody Urine	❑	Headaches
❑	Heartburn / Indigestion	❑	Problems with Urination	❑	Confusion
❑	Chest Pain	❑	Constipation	❑	Memory Loss
❑	Heart Palpitations	❑	Nausea	❑	Numbness
❑	Fever or Chills	❑	Vomiting	❑	Loss of Consciousness
❑	Night Sweats	❑	Joint Aches	❑	Insomnia
❑	Unintentional Weight Loss	❑	Muscle Weakness	❑	Seizures
❑	Weight Loss	❑	Neck Stiffness	❑	Diarrhea
❑	Fatigue	❑	Back Pain	❑	**NONE**
❑	Thyroid Problems	❑	Ankle Swelling	❑	**OTHER:**_____
❑	Hormonal Changes / Problem	❑	Hands/Fingers Sensitive to C		

Alerts (please check all that apply)

❑	Allergy to Adhesive	❑	Artificial joint replacement	❑	Are you pregnant or currently trying to get pregnant
❑	Allergy to lidocaine	❑	Pacemaker	❑	**HIV/AIDS**
❑	Allergy to topical antibiotics	❑	Require antibiotics prior to a surgical procedure	❑	**Hepatitis A,B or C**
❑	Artificial heart valve	❑	Rapid heartbeat with epinephrine	❑	**NONE**
❑	Blood thinners			❑	**OTHER:**_____
❑	Defibrillator				
❑	MRSA				

_____ _____ _____

Additional Information:

_____
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COSMETIC QUESTIONNAIRE

What would you like to learn more about? Please select all that apply:

- ❏ Facial Wrinkles
- ❏ Acne / Acne Peels
- ❏ Acne Scars
- ❏ Dark Spot Corrector
- ❏ Hair Loss
- ❏ Skin Care Regimen Advice
- ❏ Dark Spot Corrector
- ❏ Unwanted Leg Veins
- ❏ Stretch Mark Reduction
- ❏ Unwanted Facial Veins / Redness
- ❏ Botox / Fillers
- ❏ Laser Hair Removal
- ❏ Removal of Unwanted benign moles
- ❏ Excessive Sweating
- ❏ Frequent Urination / Dryness
- ❏ Cellulite
- ❏ Butt Enhancement
- ❏ Skin Tags
- ❏ Pore Size
- ❏ Skin Tightening - Face, Neck, Chest, Arms, Thighs, Abdomen
- ❏ Pregnancy Skin Care
- ❏ Fat Reduction
- ❏ Other (Please Specify): _____

Do you wear sunscreen? ◯ Yes ◯ No If yes, what SPF?: _____

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

Cosmetic Procedures - **ALL cosmetic procedures are non-refundable**

Elective cosmetic procedures are not covered by insurance companies. You are financially responsible for all charges associated with elective, cosmetic and non-covered procedures. Patients who have a cosmetic consultation will receive credit in the amount of the consultation toward their cosmetic procedure. If you are scheduled for any cosmetic procedure, please note, we require at least 48 hours notice to either cancel or reschedule your procedure so that we may accommodate another patient in your appointment slot.

1) A minimum 50% deposit is required for all appointments
2) Quotes given are valid for 30 days
3) Canceled packages & specials are prorated to the original cost and a credit will be applied to your Pure Dermatology account.

PRINT NAME: _____

PATIENT SIGNATURE: _____