Premier Dermatology
Associates of Orange County

Melissa Watcher, M.D., Susan W. Cox, M.D., Hui-Kyung Tina Kim, M.D.
Premier Dermatology Associates of Orange County
20162 SW Birch Street, Suite 250 • Newport Beach, CA 92660
Office 949-251-0427 • Fax 949-251-0480

## FINANCIAL POLICY AND AGREEMENT

Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. Should you be a cash patient, we may not ask for full payment at the time of service, although you will remain responsible for the full payment of all fees for services provided. If you have health insurance, we bill your insurance company directly, and you will be responsible for co-payments, coinsurance, deductible, and/or non-covered amounts. For your convenience, our office accepts personal checks, credit cards, and cash. Please read the following carefully, as it outlines our financial policy. It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, and disallow procedure codes, and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" charges - the amount they are willing to cover. The insurance company reduces the fees according to your individual policy's which applies amounts to your annual benefits (including co-payments, coinsurance, or deductible). This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes. Your insurance carrier will process the claim and determine reimbursement rates. Claims may also be denied depending on your benefits. By contracting with your insurance company, we are required to write-off the difference between the billed amount and the contracted amount ("reasonable and customary"). You will be billed for co-payments, coinsurance, or deductible. If we do not have a contract with your insurance carrier, you are responsible for the amount in full. We are required by all insurance carriers to collect from patients co-payments, coinsurance, or deductible amounts. These fees can be reduced only in those cases where true financial hardship can be demonstrated. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of Non-Sufficient Funds or your account is turned over to Collections, you will responsible for all related costs.

I have read and understand Premier Dermatology Associates of Orange County/Susan Cox MD, Hui-Kyung Tina Kim MD, and Melissa Watcher MD financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Premier Dermatology Associates of Orange County/Susan Cox MD, Hui-Kyung Tina Kim MD and Melissa Watcher MD I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize Premier Dermatology Associates of Orange County/Susan Cox MD, Hui-Kyung Tina Kim MD and Melissa Watcher MD, to release all information necessary to secure payment of benefits.

Patient Legal Name (please print clearly): _____

Signature: _____ Date: _____

_____
(Parent/guardian if patient is a minor)

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**Patient Consent for use and Disclosure of Protected Health Information and Notice of Privacy Practices (HIPAA)**

SUSAN COX, MELISSA WATCHER, HUI-KYUNG TINA KIM M.D.'S (THE PHYSICIANS)

The Physicians may use and disclose protected health information about me to carry treatment, payment and healthcare operations. The Physicians' Notice of Privacy Practices is available for my review and for a more complete description of such uses and disclosures, prior to signing this consent. I may obtain a copy of the Notice of Privacy Practices and any revisions thereof, upon my request.

There are some ways in which my personal information may be used or disclosed by The Physician: The Physicians may call my home or cell phone and leave a message on voice mail for such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

The Physicians may mail to my home any items that assist the practice in carrying out normal business operations, such as appointment reminder cards, insurance correspondence and patient statements.

I have the right to restrict how the practice uses or disclose my information to carry out business operations. However, the practice is not required to agree to my restrictions. If they do, I understand that reasonable requests will be accommodated, but they cannot guarantee that the requested will be fulfilled.

By signing this form, I am consenting to the Physicians' use and disclosure of my personal health information and to carry out treatment, payment and healthcare operations and acknowledging the Physicians' Notice of Privacy Policy effective April 14, 2003

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, the physicians legally will not be able to treat me. I may request a copy of this Disclosure if I desire.

_____ _____
Patient's Name (Please Print) Signature of Patient or Legal Guardian

_____ _____
Print Name of Legal Guardian Date

**PHOTO CONSENT**

We may be taking pictures **FOR INTERNAL USE ONLY**. You have the choice to opt out.

Choose one: Yes _____ I do give permission for pictures to be taken of me.

No _____ I do not want pictures taken of me.

Signature below confirms your choice listed above,

_____

Signature Print Name Date

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**PATIENT REGISTRATION**
***GENERAL INFORMATION***

_____
LAST NAME FIRST NAME M.I.

_____ SEX: M □ F □ _____
DATE OF BIRTH SOCIAL SECURITY NUMBER

MARITAL STATUS: Married☐ Single☐ Divorced☐ Widowed☐ Domestic Partner☐

***HOME ADDRESS***

_____
Street Address City State Zip Code

(_____)_____ (_____)_____
**Primary Phone Number** **Secondary Phone Number**

_____ (_____)_____
Employer Work Phone

**PARENT/GUARDIAN NAME** _____ **RELATIONSHIP**_____

**SOCIAL SECURITY NUMBER (Parent/Guardian)** _____ **DOB (Parent/Guardian)** _____

**Primary Language:** _____

**ETHNICITY:** Hispanic ☐ Not Hispanic☐ Other☐

**RACE:** American Indian/Alaska Native☐ Asian☐ White☐ Black/African American☐
Native Hawaiian Other Pacific Islander☐

WOULD YOU LIKE TO RECEIVE EMAIL UPDATES REGARDING YOUR APPOINTMENT? Yes☐ No☐

**EMAIL ADDRESS:** _____

## How did you hear about our office?

Previous patient □ Orange Office□ Silverberg's Office□ Search Engine□ Yelp□ Hoag Hospital□
Insurance□ _____ Worker's Comp.□ Advertisement□ Yellow Pages□
Physician□ _____ Friend/Family□ _____
Other□ _____
**Do you have an Advance Directive**: _____ Yes _____No

## May we leave detailed messages regarding results or any other messages? Yes ____ No ____

Who else can we speak to regarding your results _____ Relationship _____

**In case of an emergency, who may we contact?**

_____
Name Relationship Phone

**I, the undersigned, assign directly to** Premier Dermatology, Susan Cox M.D, Hui-Kyung Tina Kim M.D. and Melissa Watcher M.D, **all medical benefits if any, otherwise payable to me for services rendered. I understand that I will be required to present my health insurance card and driver's license to ensure coverage and identity. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I understand that I may elect to change health care providers at any time.**

**Signature** _____ **Date** _____

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# HISTORY AND INTAKE FORM

**Name: _____ Date of Birth: _____ Date: _____**

## Past medical history: (Please circle all that apply)

| | | |
|---|---|---|
| Anxiety | Heart Disease | Seizures |
| Arthritis | Hepatitis | Stroke |
| Atrial fibrillation | Hypertension | Thyroid Disease |
| Asthma | HIV / AIDS | Valve Replacement |
| BPH | GERD (Acid Reflex) | |
| Cancer: _____ | | |
| COPD (Emphysema) | Organ Transplant | |
| Depression | Kidney Disease / Dialysis | |
| Diabetes | Pacemaker | |
| None Other: _____ | | |

## Past Surgical History: (Please circle all that apply)

| | | |
|---|---|---|
| Heart Surgery | Joint Replacement(s): _____ | |
| Organ Transplant | Prostate Removed | |
| Ovaries Removed | Skin Cancer Surgery | |
| Spleen Removed | Hysterectomy | None |
| Other: _____ | | |

## Skin Disease History: (Please circle all that apply)

| | | |
|---|---|---|
| Acne | Dry, Itchy Skin or Scalp | Melanoma |
| Actinic Keratoses | Eczema | Psoriasis |
| Basal Cell Skin Cancer | Hay Fever / Allergies | Squamous Cell Skin Cancer |
| Blistering Sunburns | Precancerous Moles | None |
| Other: _____ | | |

Do you wear Sunscreen? Yes No
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Is there any other family history? _____

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## Medications (Please list all current medications):

_____

_____

_____

## Allergies (Please list all allergies):

_____

_____

_____

## Social History

**Smoking Status:**

Never Smoker□ Former Smoker□ Cigar Smoker□ Current Every day Smoker□

Start Date: _____ Quit Date: _____ Number of packs per day: _____ Total years Smoking: ____

**Do you drink alcohol?**

Yes No If yes, _____ drinks/day

How many times in the past year have you had 4 or more drinks in the same day? _____

**Are you pregnant?** Yes No If yes, how many weeks? _____

**Recreational drugs?** Yes No If yes, what drugs? _____

**Immunization:**

Have you had your Influenza Vaccine this year or last year? Yes□ No□ Declined□ If yes, when? _____

Have you had your Pneumonia Vaccine with in the past 5 years? Yes□ No□ Declined□ If yes, when? _____

Any other vaccinations this year? Yes□ No□

_____

What is your occupation? _____

**May we leave a detailed message on your phone? Yes No Phone: _____**

## Pharmacy Information

Name: _____ Phone: _____

Address if known: _____ City: _____

## Pediatric History (only for minors)

Gestational age at birth (in weeks): _____weeks Birth Weight: _____ lbs _____ oz

Maternal illness during pregnancy: _____

Completed by

Patient: _____ Signed by patient or responsible party

Date: _____

Medical Assistant Initials: _____ Date: _____