CALIFORNIA SKIN INSTITUTE

California Skin Institute has over 40 locations throughout California

Patient Demographic Form

Patient Name Mr. Mrs. Ms. Dr. Rev. _____
LAST NAME | FIRST NAME | MIDDLE NAME

Patient's Date of Birth _____ **Age** _____ **Gender** M F _____
xx / xx / xxxx | SOCIAL SECURITY NUMBER

Birthplace _____ **Primary Language** _____

Address _____
STREET | APT / UNIT # | CITY | STATE | ZIP CODE

Telephone _____ _____ _____
HOME (xxx) xxx-xxxx | WORK (xxx) xxx-xxxx | MOBILE (xxx) xxx-xxxx

Email Address _____ **Marital Status** (circle) Single Married Widowed Divorced Partnered

Employer _____
EMPLOYER NAME | EMPLOYER ADDRESS

Emergency Contact _____
FULL NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER

Primary Care Physician _____
LAST NAME | FIRST NAME | PHONE NUMBER

Referring Physician _____

If a Physician did not refer you, please tell us how you heard about our office

CSI Website Online Review Website Social Media ZocDoc Insurance Carrier Referral/Word of Mouth

Parent/Guardian _____
PARENT/GUARDIAN NAME | DAYTIME PHONE | RELATIONSHIP TO PATIENT | ALTERNATE DAYTIME PHONE

Primary Insurance

_____
PRIMARY INSURANCE COMPANY NAME

_____
SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT

_____
SUBSCRIBER'S ID NUMBER

_____
GROUP NUMBER | SUBSCRIBER'S BIRTHDATE

Self Spouse Father Mother Partner Other

PLEASE INDICATE RELATIONSHIP TO PATIENT

Secondary Insurance

_____
SECONDARY INSURANCE COMPANY NAME

_____
SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT

_____
SUBSCRIBER'S ID NUMBER

_____
GROUP NUMBER | SUBSCRIBER'S BIRTHDATE

Self Spouse Father Mother Partner Other

PLEASE INDICATE RELATIONSHIP TO PATIENT

PATIENT OR GUARDIAN SIGNATURE _____ **DATE** _____

CALIFORNIA SKIN INSTITUTE

PATIENT NAME _____ DOB _____

Patient Acknowledgment and Authorizations

I authorize the California Skin Institute to conduct examinations, and perform procedures as are medically required to administer treatment and medications as deemed necessary or advisable.

The California Skin Institute is hereby authorized to release a complete report of services rendered, diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billing agents, insurance carriers, employer's workers' compensation insurance company, other third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other Intermediaries responsible for payment of services rendered. The release of information consent may be revoked at any time by giving written notice.

If release of information is refused, the patient will be held responsible for payment of all charges for services rendered. In consideration of medical goods and services provided by the California Skin Institute, I give all rights, title and interest to the medical/surgical/supply reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefits including Medicare Part B. I remain fully responsible for payment of any and all charges not covered by insurance or Medicare.

Patient Assignment of Benefits

California Skin Institute will bill all primary and secondary insurances, but I am ultimately responsible for payment for the services and any supplies/equipment I receive.

I hereby assign to California Skin Institute, AMC, any insurance or other third party benefits available for healthcare services provided to me. I understand that the California Skin Institute has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to California Skin Institute, I agree to forward to the California Skin Institute all health insurance and other third party payments that I receive for services rendered to me immediately upon request.

I understand that my signature requests payment be made directly to the California Skin Institute. I authorize release of medical information necessary to pay the claim. A photocopy of this assignment is to be considered as the original.

Patient Financial Policy

Thank you for choosing the California Skin Institute, AMC, as a healthcare provider. We are committed to your treatment being a successful experience. Please help us maintain accurate records by filling out forms legibly, and inform us if any changes need to be updated on your account (for example: address, telephone number, medical insurance, etc). We require credit or debt card information to be left on file for future balance billing purposes. Copayments are due at the time of service. CSI reserves the right to send out specimens to an outside laboratory for special staining purposes, pathologic interpretation, and/or to obtain a second opinion. CSI is not responsible for any outside facility charges that may be incurred. It is your responsibility to know and understand your specific insurance plan and what benefits are provided. There is a $75 fee if appointments are not canceled or rescheduled within 24 hours of your appointment. Cosmetic appointments longer than 30 minutes require a minimum $150 deposit (excluding prepaid packages), applicable to the treatment cost. This fee is forfeited without canceling or rescheduling with a minimum of 24 hours notice. We accept all major credit cards, checks, and cash. Please review CSI's complete Patient Financial Policy attached for more information.

I have read and agree with the Patient Acknowledgment and authorizations, Assignment of Benefits, and Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

PATIENT OR GUARDIAN SIGNATURE: _____ Date: _____

CALIFORNIA SKIN INSTITUTE

PATIENT NAME _____ DOB _____

Channel of Communication Request

You have the right to request how we communicate with you. We may communicate with you by phone, text, email, or US Mail including use of automated communication devices. I hereby request the use of the following communication channels for information related to my personal health, treatment, or payment for treatment. This request supersedes any prior request for confidential communications I have made. This permission is valid for one year from the date signed. You may revoke your authorization to receive further calls or messages at any time. The revocation does not have to be in writing. The ability to receive treatment from CSI is not contingent upon your communication choices

Please circle all that apply and indicate with options(s) you prefer:

Preferred Contact Method (Circle all that apply): Phone Email Text

Primary Phone (_____)_____-_____ Alternate Phone (_____)_____-_____

_____ DO NOT leave messages on my voicemail

_____ OKAY TO leave messages on my voicemail

If you are unavailable, California Skin Institute has permission to speak with: _____

Email for Marketing Purposes Yes / No Preferred Email Address: _____

Notice of Privacy Practices

I hereby acknowledge that I was offered and/or received a copy of California Skin Institutes's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Any questions regarding the Privacy Practices of California Skin Institute should be directed to our Privacy Officer, Mike Runquist. He can be reached via email at **mrunquist@caskin.com.**

I would like to receive a copy of any amended Notice of Privacy practices (circle one): Yes / No

I prefer to receive a copy via (circle one) Email Handout Mail Fax

PATIENT OR GUARDIAN SIGNATURE: _____ Date:_____

Discrimination is Against the Law

California Skin Institute complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity, or sex. CSI does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity, or sex

California Skin Institute:

1) Provides free aids and services to people with disabilities to communicate effectively with us, such as:
   (a) Qualified sign language interpreters
   (b) Written information in other formats (large print, audio, accessible electronic formats, other formats)

2) Provides free language services to people whose primary language is not English, such as:
   (a) Qualified interpreters
   (b) Information written in other languages

If you need these services, please call our office and ask to speak with the Regional Manager. If you believe that CSI has failed to provide these services or discriminated against in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Mike Runquist**,** 525 South Dr, #115, Mountain View, CA 94040, (408) 673-9016-5600.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Mike Runquist is available to help you. You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office of Civil Rights: Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

STAFF USE ONLY

Sent/Given Copy By _____

Date _____

 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

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PATIENT NAME _____ DOB _____

Patient Medical History Form

Are you in good health now? Yes _____ No _____

Have you ever had any of the following?

Asthma	Yes _____	No _____	Diabetes	Yes _____	No _____
Chronic Hay Fever	Yes _____	No _____	Internal Cancer	Yes _____	No _____
Hives	Yes _____	No _____	High Blood Pressure	Yes _____	No _____
Sinus Problems/Migraines	Yes _____	No _____	Heart Trouble	Yes _____	No _____
Eczema	Yes _____	No _____	Rheumatic Fever	Yes _____	No _____
Boils	Yes _____	No _____	Jaundice/Hepatitis	Yes _____	No _____
Food Allergies	Yes _____	No _____	Kidney Disease	Yes _____	No _____
Allergy to Local Anesthetics	Yes _____	No _____	Glaucoma	Yes _____	No _____
Bleeding Ulcer	Yes _____	No _____	Epilepsy	Yes _____	No _____
HIV Infection	Yes _____	No _____	Tuberculosis	Yes _____	No _____
Do You Smoke?	Yes _____	No _____	Organ Transplant	Yes _____	No _____
Joint Replacement	Yes _____	No _____			
Do you take blood thinners?	Yes _____	No _____	(Blood Thinners like Aspirin, Advil, Ibuprofen, Motrin, Coumadin)		
Have you ever taken Penicillin?	Yes _____	No _____			

What disease, if any, runs in your family?

_____

_____

Have you ever been treated for skin cancer?

Yes _____ No _____

If allergic to any medication, please list and state the reaction:

_____

_____

Serious Illness? If so, please describe below:

_____

_____

Previous skin problems? Please describe below:

_____

_____

Any hospitalizations? If so, please describe below:

_____

Any surgeries? If so, please describe below:

_____

Women only, please answer the following:

Are you pregnant?	Yes _____	No _____	If yes, the expected delivery date is _____
Are you breast-feeding?	Yes _____	No _____	
Do you take birth control pills?	Yes _____	No _____	Name of brand? _____

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PATIENT NAME _____ DOB _____

Patient Medication List

Medication Name	Dosage	Frequency	Route of Administration (e.g., oral, topical, inhaled)

Patient Skin Concerns

Skin Concerns (check all that apply)

- ___ Brown Spots/Age Spots
- ___ Fine Lines/Wrinkles
- ___ Pore Size
- ___ Scarring/Acne Scars
- ___ Skin Texture/Skin Tone
- ___ Torn Earlobe
- ___ Veins/Broken Capillaries
- ___ Varicose Veins
- ___ Loose Sagging Skin
- ___ Frown Lines
- ___ Freckles/Pigmentation
- ___ Heavy Wrinkle Reduction
- ___ Sun Damage
- ___ Skin Redness
- ___ Sagging or Puffy Eyelids
- ___ Excessive Sweating
- ___ Hair Loss
- ___ Neck Fat/Excessive Skin
- ___ Under Eye Circles
- ___ Unwanted Mole
- ___ Skin Tightening
- ___ Complexion
- ___ Lip Volume
- ___ Older Looking Hands
- ___ Cellulite
- ___ Hair Removal
- ___ Belly Fat/Spare Tire
- ___ Facial Volume Loss
- ___ Nose Shape or Contour
- ___ Jawline Definition
- ___ Unwanted Arm/Thigh Fat
- ___ Breast Enlargement/Reduction
- ___ Jowls or Weak Chin
- ___ Nail Fungus
- ___ Neck Skin
- ___ Fat Reduction

Specialty Services (check those you are interested in)

- ___ Ultherapy
- ___ Cellulaze
- ___ Aesthetician Services
- ___ Liposonix, CoolSculpting, SmartLipo
- ___ Kybella
- ___ Thermage, Titan
- ___ DermaSweep
- ___ Injectables/Fillers
- ___ Dr Morganroth's Vertical Vector Facelift (Local Anesthesia)
- ___ Tattoo Removal
- ___ Mommy Makeover
- ___ Dermapen
- ___ Breast Reduction/Lift/Implant
- ___ Fraxel/IPL
- ___ miraDry
- ___ Face/Neck Rejuvenation
- ___ Laser Eyelid Rejuvenation

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Patient Financial Policy

Thank you for choosing the California Skin Institute, AMC, as a healthcare provider. We are committed to your treatment being a successful experience. Please help us maintain accurate records by filling out forms legibly and inform us if any changes need to be updated on your account (for example: address, telephone number, medical insurance, etc). You may contact our Billing Department at (408) 369-5600, option 6, Monday - Friday from 8:00AM to 5:00PM. We accept all major credit cards, checks and cash.

Insurance and Insurance Collection

If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay for services at the time of service. If we are able to collect from your insurance company after you have fully paid your account, we will issue you a refund. We will gladly bill your insurance company, if contracted, as a courtesy. In the event that your insurance does not reimburse us within ninety (90) days, we will transfer this balance to you as your responsibility and send you a statement.

Know Your Plan Benefits – Non Covered Services Are Your Responsibility

Each and every insurance company, including Medicare, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have relative to your own benefits. All co-payments, co-insurance, and/or deductibles are your responsibility. Co-payments are due at the time of service. This is a requirement of your insurer.

We may decline to see patients for non-emergent visits if co-payments are not made at the time of the visit. In addition, please be aware that your California Skin Institute physician may provide services that may not be covered as a benefit of your specific insurance plan. Patients or Guarantors are financially responsible for any and all services provided that may not be covered by your insurance plan. It is your responsibility to know and understand your specific insurance plan and what benefits are provided.

Some procedures you may undergo are best performed utilizing the equipment, safety, and comfort that can be obtained in an Ambulatory Surgery Center (ASC) setting. Please be aware that these charges are separate and apart from those fees charged by the physicians of the California Skin Institute. You should ask your insurer how your benefit plan would cover any outpatient facility/ASC charges.

Some procedures you may undergo will involve removing tissue. The charges for this process are known as Laboratory/Pathology charges and will appear on your bill if performed. The physician who looks at the slide and provides his/her opinion based on those slides is known as the Pathologist. There is a charge for that physician's professional opinion, which is independent of the charge for preparing the actual slide. CSI reserves the right to send specimens to an outside facility for special staining purposes, pathologic interpretation, and/or to obtain a second opinion. CSI is not responsible for any outside facility charges that may be incurred.

HMO Plans

If your care and treatment at the California Skin Institute is the result of a referral from your HMO plan and/or from your Medical Group or HMO Provider, you should have a written authorization/referral from them. It is your responsibility to verify that they properly authorize your care and treatment in advance. Any co-pay required will be your responsibility at the time of each visit.

Secondary Insurance

Having more than one insurance does NOT necessarily mean that your services are covered 100%. Depending on your plan's benefits, the secondary insurers will pay as a function of what your primary insurer pays. We will bill your secondary insurer as a courtesy. You are responsible for any balances after your insurers have processed our claims.

Medicare

You are responsible for your annual deductible and 20% of the allowable fee for covered services. We will be happy to bill and secondary (or Tertiary) insurance you may have once we have been informed that you have such coverage in effect. If any balance remains after your claims have been processed, we will transfer responsibility of payment to you and send you a statement.

Important reminder for Medicare enrollees: If you qualified for Medicare coverage and decided to enroll in a Medicare+Choice/Medicare Advantage plan (e.g. Secure Horizons, Blue Cross Senior Secure, SCAN) you may need to first get a referral from your Primary Care Physician (PCP) before your visit with us will be covered. Please call the number on your insurance card for information from that plan.

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Minor Patients

The adult accompanying a minor and the minor's parents or guardians are responsible for full payment for services rendered. If a minor is unaccompanied, consent for treatment and payment arrangements must be provided in advance of treatment. Payment may be by pre-authorized credit card, payment on account in advance, or check or credit card presented at the time of service.

Divorce Decrees

California Skin Institute is NOT a party to any divorce decree. Adult patients are responsible for their bill at the time of service. Financial responsibility for a minor receiving medical services rests with the accompanying adult.

Credit Card On File

Effective Nov.1, 2016 we require patients to provide a credit card for payment of co-payments, co-insurnance amounts, deductibles, and charges otherwise not covered by your insurance. The card will not be charged until the claim has been processed and we have received an Explanation of Benefits (EOB) detailing the amount of the charges that you are responsible for. You will receive the same EOB directly from the insurance company or Medicare. Once we have processed your credit card, you will receive a statement from us reflecting that payment. The credit card information will be held securely, and this process will be similar to cards on file during a car rental or hotel stay. If you prefer not to provide a credit card to be kept on file, you may pay for your services at the time of the visit.

Return Check Fee

There is a $25.00 banking fee for all returned checks. This sum is used to offset the fees incurred by California Skin Institute by our bank. If your check is returned from the bank, we may NOT ACCEPT an additional check as payment on your account. Future payments must be made with cash, money order, or credit card.

Collections

California Skin Institute will send you a statement after your insurers have been billed and your insurers have considered your charges. We will charge interest of 1.5% (18% annually) on all outstanding balances after 30 days. If no payment is received after 120 days, your account may be turned over to a collections agency. A $25.00 late payment/pre-collection fee will be added to your account to offset the administrative costs incurred when accounts are assigned for collection.

Missed Appointments

There is a $75.00 missed appointment fee if you cancel or reschedule an appointment with less than 24-hour advance notice, or if you fail to arrive for your appointment. Please do not rely on our automated appointment reminder service as your only reminder to keep your scheduled appointment, as we cannot guarantee this service, or that the phone number provided is accurate or functional for this purpose.

Promotional Coupons/Incentives

Some manufacturers offer certain discounted products and/or services. California Skin Institute may not honor or accept every coupon or manufacturer's offer as the terms and performance of the issuer may change. You are responsible for any goods and/or services you receive. Please ask whether any coupons are still being honored before receiving services. Cosmetic procedure refunds paid by credit or debit card will be subject to a 5% processing fee, which will be subtracted from the total refund amount.

Request for Medical Records

A signed release of records form is required at the time of your request. You will be charged $0.25 cents per page copied, plus clerical fees of $25.00. If you request the records to be mailed to you, please note that postage fees are not included, and will be charged separately. The medical records will not be released to you until our fees are paid in full. These fees are set by the State of California (Health & Safety Code section 123110), not California Skin Institute.