PATIENT REGISTRATION

Today's Date: ____/____/_____

Name: _____ **Sex: M F** **Date of Birth:**_____ **Age:**_____

Email: _____

Responsible Party Name (Parent, if Minor):_____

Home Address:_____ **Apt #** _____

City_____ **State**_____ **Zip**_____

Billing Address if Different:_____ **Apt #** _____

City_____ **State**_____ **Zip**_____

Home Phone #:( )_____**Cell Phone #:( )**_____

Primary Care Doctor's Name:_____

Emergency Contact Name, Relationship & Phone Number:_____

PRIMARY INSURANCE

Insurance Co. Name:_____

Policy Holder Name: _____

Relationship to Patient: self spouse child other (circle)

Policy Holder Sex: M F Birth Date:_____

SECONDARY INSURANCE

Insurance Co. Name: _____

Policy Holder Name: _____

Relationship to Patient: self spouse child other (circle)

Policy Holder Sex: M F Birth Date:_____

YES_____ NO_____ Do you authorize DHRS to call you at the number above and **leave a message** on an answering device or with another person who answers the phone to assist office in carrying out appointment reminders, lab results, med. information, treatment, payments, insurance items & operations.

YES_____ NO_____ **I AGREE** to permit Dermatology & Hair Restoration Specialists to request and obtain or forward previous medical records if deemed necessary to provide me with proper care and treatments

==========

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep a record of the health services we provide you. You may ask to see and copy that records. You may ask to correct that record. You may see your record or get more information about it by contacting this office and asking for Privacy Officer. I understand that, under the Health Insurance portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to perform the following: 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 payers. 3. Conduct normal healthcare operations such as quality assessments and physicians' certifications. I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.* 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 do agree then you are bound to abide by such restrictions.

By my signature below I acknowledge the receipt of the Notice of Privacy Practices & Agree to all of the above information:

Signed (Patient or parent, if minor) _____ Date: _____

MEDICAL HISTORY FORM

Referring Doctor: _____
Reason of your Visit: _____
Allergies :_____ _____
Medications: _____
_____
Medical problems: _____

Do you have now, or have you ever had diseases or conditions of: (Please check **Yes** or **No**)

Lungs:	**Yes**	**No**	**Other Systemic:**	**Yes**	**No**
Bronchitis/Emphysema	□	□	Diabetes	□	□
Asthma	□	□	Thyroid/Endocrine	□	□
Cough	□	□	Kidney	□	□
			Stomach Ulcer	□	□
			Hepatitis B or C	□	□
Vascular:	**Yes**	**No**	Glaucoma	□	□
Chest Pain	□	□	Arthritis/Joint Deformity	□	□
Heart Attack	□	□	Convulsions, Epilepsy	□	□
Heart Disease	□	□	Fainting	□	□

Have you ever had skin cancer? □ YES □ NO If YES, what? _____
Family history of any skin diseases? □ YES □ NO If YES, what? _____
Any history of Congenital Heart Disease/Heart Murmur? □ YES □ NO
Are you pregnant? (Women) □ YES □ NO Due Date: _____
Do you have artificial joints/valves? □ YES □ NO
Do you have **pacemakers/defibrillators**? □ YES □ NO
Do you use IV drugs? □ YES □ NO
Exposed to **HIV/AIDS?** □ YES □ NO
Any bad reactions to dental anesthesia (Novocain)? □ YES □ NO
Are you on blood thinners? □ YES □ NO Aspirin / Plavix / Coumadin

AUTHORIZATION TO RELEASE INFORMATION: I authorize DHRS to release to my insurance company any information required to receive payments in the course of my examination and treatment which could include HIV, communicable disease or drug abuse.
AUTHORIZATION TO PAY: I hereby authorize payment directly to DHRS for the surgical and/or medical benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for charges not covered by insurance company.
MEDICARE RECIPIENTS ONLY: For billing Medicare, I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to the practice for any services furnished to me by the providers. I authorize any holder of my medical information to release to the Center for Medicare and its agents any information needed to determine theses benefits or the benefits payable for related services
Check Authorization: Pt. authorizes doctor to deposit checks received on Patient's account when made out to the patient. I authorize the doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. A photocopy of this Assignment shall be considered as effective & valid as original.
Financial Responsibility for Cosmetic Procedures: I agree to be financially responsible for any cosmetic and non-covered services
CONSENT FOR COMMON PROCEDURES/MEDICATIONS: I voluntarily give my consent for some of the most common medications prescribed, and treatments & procedures performed by Dr. Behnam, which include but not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), intralesional Kenalog injections, incision & drainage, cautery and cauterization (aka electrodessication), removal of skin tags, shave biopsy & punch biopsy of skin lesions and rashes, surgical excisions, debridement of wounds, injection of skin lesions, paring down of skin lesions, all medication consents including but not limited to doxycycline, minocycline, isotretinoin, erythromycin, BP, clindamycin, tretinoin, avodart, finasteride, minoxidil, cephalexin, ketoconazole, oral and topical steroids, Lamisil, topical chemotherapy crms such as effudex, and cosmetic procedures like chemical peels, TCA, Botox, Xeomin, Dysport, fillers including but not limited to any forms of Juvederm, Restylane, Radiesse, Sculptra and laser treatments incl. but not limited to CO2, 755 and 1064 lasers, vbeam, coolsculpting, and ultherapy. Dr. Behnam will discuss the details, side effects, risks, benefits, advantages, disadvantages and alternative treatments relating to the procedures / treatments and medications and obtain oral consent prior to performing the procedure/or prescribing the medications. By Allowing Dr. Behnam to perform the procedure or prescribe the medications, you consent to side effects, risks, benefits, advantages, disadvantages of such procedures/medications.

_____ _____
Patient Signature Date

HELPFUL INFORMATION ABOUT YOUR DEDUCTIBLE

OFFICE POLICY: If you have a deductible, it is your financial responsibility to pay the bill and NOT your insurance company. Our office policy is that patients with a deductible are responsible to pay the deductible portion up front. We still bill your insurance company.

Definitions

Co-pay: If you have a Copay, the law mandates that you must pay this at every visit.
Deductible: Amount you have to pay before the insurance companies start to pay for any medical visits
Co-insurance: It's a percentage amount that you must pay after deductible has been met.

What is a deductible?

This is the amount you have to pay before the insurance companies start to pay for any medical visits or procedures.

I have a Co-pay, do I still have to pay my deductible?

YES. You have to meet your deductible before the insurance companies start to pay for any medical visits or procedures.

I have ZERO deductible, do I still have to pay anything?

YES. Besides a deductible, insurance also have a Co-insurance. It's a percentage amount that you must pay after deductible has been met. This is usually 10% or 20%, or maybe more. It is very difficult to determine this.

When the front office receptionists tell me that "My insurance covers the visit " or "I'm in network", what does this mean?

This means that your insurance company and our office have a contract to see you at a discounted rate. However, this does not mean that you don't have to pay anything. All deductibles, Co-pays and Co-insurances still apply. This means that the insurance company will not fully pay for your visit until you have fully paid for the deductible.

I acknowledge that Dr. Behnam's office can not accurately check my deductible or Co-insurance. I understand that I may have to pay for all or a portion of my visit. I am responsible for any deductible I may have based upon the insurance policy I have purchased.

NAME: _____ DATE: _____

WE ARE HERE TO HELP. ASK US ANY QUESTIONS YOU HAVE.