DERMATOLOGY & LASER CENTRE
Studio City • Simi Valley

Patient Information

First Name: _____ Last Name: _____ Sex: ❑ Male ❑ Female

Address: _____ Apt. # _____ Date of Birth: _____

City, State: _____ Zip Code: _____ Age: _____

Phone: (____) _____ ❑ Home ❑ Work ❑ Other Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Phone: (____) _____ ❑ Work ❑ Cell ❑ Other

E-Mail: _____

Social Security #: _____

Primary Care Physician _____ ❑ None

Ethnicity: ❑ Non-Hispanic ❑ Hispanic

Preferred Pharmacy _____ Location: _____

Referring source: ❑ Doctor _____ ❑ Patient ❑ Newspaper ❑ Website ❑ Other

Emergency Contact/Responsible Party

Name: _____ Relationship to the patient: ❑ Spouse ❑ Parent ❑ Child ❑ Siblings

Phone: (____) _____ ❑ Home ❑ Work ❑ Other

Patient/Responsible Party Employment Information

Are you: ❑ Employed ❑ Unemployed ❑ Self Employed ❑ Retired ❑ Student

Occupation: _____ Address: _____

Employer: _____ Phone: (____) _____

Insurance Information

❑ PPO ❑ POS ❑ HMO ❑ Other _____

Insurance Carrier Name: _____

Insured: ❑ Self ❑ Spouse ❑ Parent ❑ Other

Insured Name: _____

Insured Date of Birth: _____

Insured ID #: _____

Policy Group #: _____

Group Name: _____

❑ Medicare #_____

❑ Medi-Cal #_____

Referring Physician: _____

Assignment and Release

I directly assign all medical/surgical benefits to *Dr. Rubinstein* and understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original and authorize its use for insurance claims submission.

Signature: _____ Date: _____

Patient or Guardian

MEDICAL HISTORY FORM

Name _____

Reason for visit today:

Medical Dermatology	Aesthetic Dermatology	Laser Therapies
❑ Skin Lesion(s)	❑ Cosmetic Consultation	❑ PhotoFacial
❑ Skin Exam	❑ Neuromodulators	❑ Vascular (red) lesions or veins
❑ Rash	❑ Fillers	❑ Laser Hair Removal
❑ Warts	❑ Sculptra	❑ Laser Tattoo Removal
❑ Acne	❑ Chemical Peel	❑ Skin Resurfacing /Tightening
❑ Acne Laser/PDT	❑ Aesthetician Consultation	❑ Laser Body Contouring

Other _____

Height: _____feet ____ inches Weight: _____ lbs Recent weight gain/loss? ❑ Yes ❑ No

❑ Smoker ____ per day ❑ Quit When?_____ ❑ Alcohol _____ per week ❑ Recreational Drugs _____

Place an X in the appropriate column on the left.

YES	NO	PRIOR MEDICAL HISTORY	DATE BEGAN and EXPLANATION (IF YES)
		Asthma	
		Bleeding/Blood Disorder	
		Cancer	
		Chest Pain/Tightness/Tuberculosis	
		Colon Cancer	
		Diabetes	
		Dry Skin	
		Eczema	
		Heart Disease/Heart Attack/Stroke/Pacemaker	
		Hepatitis	
		Herpes/Shingles	
		High Blood Pressure	
		HIV/AIDS	
		Kidney Disorders	
		Thyroid Disorders	
		Other	

LIST KNOWN DRUG ALLERGIES:

LATEX: ❑ Yes ❑ No

LIDOCAINE: ❑ Yes ❑ No ❑ **None**

PENICILLIN: ❑ Yes ❑ No

OTHER:

LIST MEDICATIONS YOU PRESENTLY TAKE:
(Including Herbs and OTC meds)

❑ Aspirin ❑ **None**

❑ List attached

SKIN HISTORY (circle): ❑ **None**

Actinic Keratosis, Basal Cell Carcinoma, Eczema, Malignant Melanoma, Psoriasis, Squamous Cell Carcinoma, Urticaria, Other Suspicious Lesions

LIST PREVIOUS HOSPITALIZATIONS AND OPERATIONS ❑ **None**

❑ Pacemaker:

❑ Artificial joints: _____

Reviewed by _____ **MD Date** _____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dr. Rubinstein may use and disclose protected health information (PHI) about me **to carry out treatment, payment and healthcare operations** (TPO). Please refer to Dr. Rubinstein's Notice of Privacy Practices for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Rubinstein reserves the right to revise his Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written notice to Gennady Rubinstein, M.D. 3959 Laurel Canyon Blvd., Suite F, Studio City, CA 91604.

With my consent, Dr. Rubinstein or his staff may **call** my home or other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and call pertaining to my clinical care, including laboratory results among others.

With my consent, Dr. Rubinstein or his staff may **mail** to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they marked Personal and Confidential.

With my consent, Dr. Rubinstein or his staff may **e-mail** to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Rubinstein or his staff restrict how they use or discloses my PHI to carry out TPO.

With my consent, Dr. Rubinstein or his staff may **text** to my cellular telephone or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders or other information related to carrying out TPO. I have the right to request that Dr. Rubinstein or his staff restrict how they use or disclose my PHI to carry out TPO. I understand that standard text message rates may apply.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent Dr. Rubinstein and his staff to use and disclosure my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Rubinstein may decline to provide treatment to me.

I understand that I can request a full copy of the practice's Notice of Privacy Practices.

Patient's Name	Signature of Patient or Legal Guardian	Date

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Our Financial Policy

We are dedicated to proving the best possible care for you. We want you to completely understand our financial policies.

1. _____ **Payment is due at the time of service.**
Initial We accept major credit cards, cash and checks (personal checks up to $50 only). There will be a charge of $30 for all returned checks.

2. **Fees** – There is a fee for medical care. Fees are posted in the office and may be requested prior to services being performed.

3. **Consultation Fee** – there is a fee for your consultation with the doctor or other providers:.

	New Patient	F/U or Established
Dr. Rubinstein	$240	$ 140
Physician Assistant	$220	$ 120
Nurse Practitioner	$220	$ 120

4. **Procedures** beyond the physician/staff consultation/office visit are **charged separately for each procedure performed (i.e. biopsy, freezing, injections, etc.)** in addition to the office visit fee. Procedures may also be subject to different insurance benefits than the office visit. Your annual deductible and co-insurance charges may apply. You may request to discuss any fees beyond your office visit co-pay or co-insurance in advance of your treatment.

5. **If you have medical insurance** – As a service to you, we will file your insurance claim if you assign benefits to the doctor – in other words, if you agree to have your insurance carrier pay the doctor directly.

6. _____ **Any co-payments, co-insurance and deductibles are due at the time of your visit** (up to the amount we can reasonably estimate will be due according to your insurance policy). You will be billed for all outstanding balances. FEDERAL AND STATE LAWS AND MANAGED CARE CONTRACTS MANDATE THAT WE COLLECT ALL APPLICABLE CO-PAYS AND DEDUCTIBLES. You may request to discuss your fees before your treatment.
Initial

7. If you have not met your **deductible** or if your deductible applies to office visits, we may collect a deposit towards your services on the day of your visit and before any procedures are performed.

8. If we are unable to verify your insurance coverage at the time of your visit, we will ask you to pay for all services at the time of your visit. If we later receive a payment from your insurer, we will refund overpayment to you in a timely manner.
If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a payment from your insurer, we will refund overpayment to you.

10. We have made prior arrangements with many insurance companies to accept an assignment of benefits. If we are listed as participating providers in your plan, you will only be responsible for any amounts not paid by your policy, including co-payment, co-insurance and deductible amounts. If we do not have prior arrangements with your insurance carrier, we will prepare the claim and submit it to your insurance, however, you may be responsible for the entire bill.

11. **Not all insurance plans cover all services.** In the event that your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon the receipt of a statement from our office.

12. Please **notify us immediately if your insurance has changed.** Failure to notify us may result in no payment of services and thus transfer the financial responsibility to you.

13. **IF YOU HAVE AN HMO** – Please note that we DO NOT participate with any HMO plans.

14. If you are insured through Covered California, please confirm that we participating providers with your plan. Otherwise you are responsible for payment for all services at our private pay rates. We will bill your insurance company as a courtesy and you will be reimbursed directly according to your policy and benefits.

15. _____ **Cosmetic Procedures** – payment for all cosmetic procedures will be collected prior to the procedure being performed. We cannot accept personal checks for cosmetic procedures. Payment for cosmetic services is non-refundable after services are performed. Cosmetic visit fees do not include medical dermatology related services.
Initial

16. _____ **CANCELLATION POLICY**
Initial
    - 24 hour notice is required to cancel or reschedule an appointment.
    - **A fee of $50 may be assessed if you fail to keep your appointment.**
    - A deposit of $50 may be required for appointments over 45 minutes.
    - Laser and cosmetic appointments may require a higher deposit and cancellation fee.
    - If you miss more than one appointment, a credit card may be required for future appointments.

17. We reserve the right to refuse service to anyone. You may be discharged from our practice for non-payment of outstanding balances or other reasons.

_____ × _____ _____
Patient Name Patient/Parent Signature Date