PACIFIC COAST DERMATOLOGY

13768 Roswell Ave, Suite 102
Chino, CA 91710
Phone (909) 364-1959
Fax (909) 752-4171
www.PacificCoastDerm.com

PATIENT REGISTRATION

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr.

Patient _____ today's Date_____
Last Name First Name MI

Address _____ _____ _____ _____-_____
Street City State Zip (9 digit format)

Birth date_____/_____/_____ Age_____ Social Security #_____

Marital Status □ Single □ Married □ Widowed □ Divorced

Race: _____ Primary Language Spoken: _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

If Student: □ Full Time □ Part Time Name of School: _____

Patient's Employer_____ Patient's Occupation _____

In case of an emergency, whom can we contact?

Name_____ Relationship_____ Phone_____

Primary Care Physician: _____ Referring Physician: _____

Mailing address (if different from above)

_____
Street City State Zip

PERSON RESPONSIBLE FOR PAYMENT (ONLY for minor patient)

Name _____ Relationship to patient _____
Last Name First Name MI

Address _____
Street City State Zip

Home Phone (____) _____ Work Phone (____) _____

Birthday____/____/_____ Social Security #_____ Sex □ Male □ Female

---

Do we have your permission to:

Email you (non-medical) info, events and specials? □YES □NO if yes, Email: _____

Leave a message on your answering machine at home? □YES □NO if yes, Brief or Extended

Leave a message on your cell phone? □YES □NO if yes, Brief or Extended

Leave a message at your place of employment? □YES □NO

Discuss your medical condition with any member of your household? □YES □NO

If yes, whom: _____ Relationship _____

_____ _____
Patient or Legal Guardian Signature Date

FLIP OVER

PACIFIC COAST
DERMATOLOGY

13768 Roswell Ave, Suite 102
Chino, CA 91710
Phone (909) 364-1959
Fax (909) 752-4171
www.PacificCoastDerm.com

INSURANCE INFORMATION

Please present insurance card at the time of check in. ALL CHARGES ARE DUE AT TIME OF SERVICE.

Primary Insurance Name	Secondary Insurance Name
Name of Insured	Name of Insured
DOB of Insured	DOB of Insured
Insured ID #	Insured ID #
Group #	Group #
Employer Name	Employer Name
Employer Phone	Employer Phone
Relationship to Insured	Relationship to Insured

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I authorize Pacific Coast Dermatology to release to the Social Security Administration and Center for Medicare Service, or its intermediaries or carrier, any information needed for this or a related Medicare claim.

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or on my behalf to Pacific Coast Dermatology (Dr. T. Anthony Hoang-Xuan, FAAD) for any services furnished to me by this office. Regulations pertaining to Medicare of benefits apply. This authorization is valid until revoked in writing. If I do not sign this consent, or later revoke it, Dr. Hoang-Xuan my decline to provide treatment to me.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of any information needed to act upon this request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges to the physician for his services. I understand I am fully responsible for any remaining balances. I also understand that if my insurance requires a written referral or pre-authorization from my primary care physician, I am responsible to ensure that one is provided before the visit occurs (even if this office schedules an appointment with Dr. Hoang for me) or I will be liable for the full charges incurred.

Pacific Coast Dermatology/Dr. Hoang-Xuan DOES NOT PARTICIPATES with any of the Medicare HMO plans.

Pacific Coast Dermatology/Dr. Hoang-Xuan DOES NOT fill out any worker's compensation paperwork. I am responsible for full payment for services rendered by Dr. Hoang-Xuan even if my skin condition is work-related.

If I have Medigap coverage, I request authorized Medigap benefits to be made on my behalf to Pacific Coast Dermatology (Dr. T. Anthony Hoang-Xuan, FAAD) for any services furnished to me. I authorize Pacific Coast Dermatology to release to my Medigap carrier any information needed to determine these benefits for the benefits payable to related services.

_____ _____ _____

Signature of patient/policy holder/legal guardian | Print Name & Relationship to patient (if not patient) | Date

PACIFIC COAST DERMATOLOGY

13768 Roswell Ave, Suite 102
Chino, CA 91710
Phone (909) 364-1959
Fax (909) 752-4171
www.PacificCoastDerm.com

MEDICAL HISTORY

Name: _____ **Date**: _____

Reason for Visit: _____

Please note that insurance companies and Medicare consider the removal of benign growths NOT medically necessary and DO NOT reimburse these procedures.

Do you have or have had any of the following? *(If yes, please check)*

- □ Acne
- □ Actinic Keratosis
- □ Artificial heart valve
- □ Artificial Joints or Metal Implant
- □ Asthma
- □ Atopic Dermatitis
- □ Atrial Fibrillation
- □ Autoimmune disease (Lupus, Rheumatoid Arthritis)
- □ Bleeding disorder / Blood Clots
- □ Chronic Fatigue/ Fibromyalgia
- □ Cold Sores/ Herpes
- □ Diabetes
- □ Depression
- □ Down's Syndrome
- □ Migraines
- □ Epilepsy/Seizures
- □ Heartburn/Ulcer/Gastritis/Reflux
- □ Heart disease
- □ Hepatitis/ Jaundice
- □ High Blood Pressure
- □ HIV
- □ Keloids or Abnormal Scarring
- □ Kidney / Liver / Lung disease(s)
- □ Multiple Sclerosis
- □ Melanoma
- □ Pacemaker/ Defibrillator
- □ Psoriasis
- □ Seasonal allergies
- □ Skin Cancer (BCC or SCC)
- □ Thyroid trouble
- □ Cancer (what type? _____)
- □ Other conditions

Please list: _____
_____
_____

□ **Please list any medications you are currently taking:**
□ **No current medications.**

_____ _____
_____ _____
_____ _____
_____ _____

Please list major surgeries:

_____Date:_____

Please list major hospitalizations:

_____Date:_____

• ALLERGIES

Any medications? □ No □ Yes (Please list)_____

Tape or bandages? □ No □ Yes

Numbing medications or dental anesthesia? □ No □ Yes

Please list any other allergies _____

• ALLERGIES

FLIP OVER

PACIFIC COAST DERMATOLOGY

13768 Roswell Ave, Suite 102
Chino, CA 91710
Phone (909) 364-1959
Fax (909) 752-4171
www.PacificCoastDerm.com

MEDICAL HISTORY

Please list any relatives that have had any of the following conditions? (father, mother, brother, sister)

- □ Skin Cancer:_____ □
- □ Eczema:_____
- □ Melanoma :_____
- □ Diabetes:_____
- □ Elevated Cholesterol:_____
- □ Seasonal Allergies:_____
- □ Psoriasis:_____
- □ Autoimmune disease:_____
- □ Cancer:_____
- □ Other:_____

How many of the following do you have? Brothers:_____ Sisters:_____ Sons:_____ Daughters:_____

Please answer the following questions:

Tanning bed used?	□ Yes	□ No
Do you regularly use sun screen	□ Yes	□ No
Drugs	□ Yes	□ No
Do you drink alcoholic beverages?	□ Yes	□ No
Exposed to HIV	□ Yes	□ No
Exposed to HEP A, B, C, D	□ Yes	□ No
Sexually Active	□ Yes	□ No

Smoking status? □ Never been a smoker □ Former smoker □ Current sometimes smoker □ Current every day smoker

I certify that this history form is filled out completely and accurately. I have answered all questions truthfully and to the best of my knowledge.

Patient or Legal Guardian's Signature **Date**

HOW DID YOU HEAR ABOUT US?

We would appreciate your response in following section.

□ Physician (Dr. _____) □ Family or Friend (name: _____)

□ Insurance Website/Book □ Internet Search □ Other: _____

PACIFIC COAST
DERMATOLOGY

13768 Roswell Ave, Suite 102
Chino, CA 91710
Phone (909) 364-1959
Fax (909) 752-4171
www.PacificCoastDerm.com

FINANCIAL POLICY

Thank you for choosing Pacific Coast Dermatology as your dermatology provider. We are committed to your treatment being a successful. Our Insurance Department and Patient Finance Counselor will work very hard to make sure your paperwork is filed accurately and promptly.

In order to provide you with the highest quality service while keeping our billing costs low, we offer EASY-PAY. We simply maintain your credit/debit on file to satisfy all co-pays, deductibles, and balances not covered by your insurance. We will continue sending paper statement to you and balance is due upon receipt. If you wish to send in a check, please call our office within ten days of receiving our statement. Otherwise, the balance due will be charged on the credit card on file. Our Patient Finance Counselor will be more than happy to give you more information about EASY-PAY.

We accept VISA, MASTERCARD, DISCOVER, DEBIT CARD, and CASH.

TREATMENT CONSENT FOR UNACCOMPANIED MINOR PATIENT (under 18 years of age):
I state that I am the legal guardian of this patient. I authorized Dr. Hoang-Xuan and/or medical staffs under his discretion to render medical care even if I cannot be present. I also understand that I will be responsible to pay any bills that are incurred as a result of the visits.

_____	_____	_____
Signature of Parent or Legal Guardian	Relationship to Patient	Date

INSURANCE AND INSURANCE COLLECTION:

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments. To that end, our billing staff has undergone extensive and rigorous training to maximize your insurance reimbursement, while reducing the time by which they pay. Please **initial** next to your category of insurance listed below, as this will help us speed up payment and eliminate any confusion in the future. Thank you.

Plans in which we are a participate providers:
Aetna, Blue Cross, Blue Shield, First Health, Great West, Health Net, TriCare, and United Health Care/PacifiCare
_____ **PPO PLANS**. We have agreed to accept the discounted rate from your plan; however, all co-insurance, copay, and deductible are your responsibility. We will estimate balances to the best of our ability.

Medicare:
_____ As a participating provider, we may bill your Medicare carrier. You are responsible for your 20% co-payment and annual deductible and we must collect it each and every visit. If you prefer, we can bill your co-pays to your EASY-PAY account on a weekly, biweekly, or monthly basis.

Secondary Insurers:
_____ Having more than one insurer DOES NOT necessarily means that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

Usual & Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

Divorce Decrees:
_____ This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minor rests with the accompanying adult.

FLIP OVER

PACIFIC COAST
DERMATOLOGY

13768 Roswell Ave, Suite 102
Chino, CA 91710
Phone (909) 364-1959
Fax (909) 752-4171
www.PacificCoastDerm.com

Interest, Rebilling, Collections Fees:
We are not a billing company. We reserve the right to charge monthly interest in the amount of 1½ % as provided by state law on any balance over 30 days past due, or rebilling fee of $5 per bill (whichever is more). Any account over 60 days past due will be sent to a third party collections agency and $25 administration fee will be added to the account balance.

Missed Appointment/No Show Fees:
If you must cancel or reschedule an appointment, **please call us at least 24 hours before your scheduled appointment**. Pacific Coast Dermatology, Inc. charges a fee of $20 to all patients who missed their appointment or do not notify our office of the cancellation 24 hours in advance. Please remember that our policies are created to allow for effective scheduling and to ensure all patients wishing to receive services be accommodated. Please help us to better serve you.

Medical Records Fees:
In pursuant to CA Health & Safety section 123110, we charge $0.25 per copy plus $25 for clerical fees. All medical records will take 7-10 business days to be completed.

Returned Checks:
Any checks returned NSF or for any other reasons, $20 fee will be added to your account to cover the bank charge. We participate in San Bernardino County District Attorney's Check Enforcement Program. If your check was returned for any reasons, we will notify you and request for payment plus $20 fee. We will also allow 10 days for you to comply with our request. If you failed to comply with our request or you do not contact us to arrange payment within the 10 days grace period, we will have no choice but refer your check to San Bernardino County DA's Check Enforcement Program.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree with this Financial Policy

X _____ _____ *Date*: _____/_____/_____
Signature of Patient / Guardian / Responsible Person — Print Name of Guardian/Responsible Person & Relationship

---

Privacy Practice (HIPAA)

By signing below, I acknowledge that I have a copy of Pacific Coast Dermatology's Notice of Privacy Practices.

Signature: _____ *Date*: _____/_____/_____