Dermatology & Cosmetic Care
425 Haaland Drive Suite 204, Thousand Oaks, CA 91361
Tel: 805-497-8080 Fax: 805-497-8806 Website: www.evenyoungerskin.com

Patient Information Form

Last Name_____ First Name_____ Middle Initial_____

Address_____

City_____ State _____ Zip Code_____

Day Phone:_____ Cell Phone:_____ Home Phone:_____

Date of Birth _____ Marital Status_____ Gender_____

Social Security #_____ Driver's License #_____

Occupation_____ Employer_____

Work Address_____

Work Phone_____ E-Mail Address_____

Emergency Contact:_____ Relationship: _____

Day Phone:_____ Cell Phone:_____ Home Phone:_____

****Please include the following information if the Patient is a minor****

Parent/Guardian Name_____ Relationship to Patient_____

Phone #_____ Cell Phone#_____ Drivers License #_____

May we leave personal medical information on your home answering machine? _____YES _____NO

May we discuss your medical information with family members/ primary physician? _____YES _____NO

If yes, please provide their names and phone numbers below.

Name:_____ Relationship: _____

Day Phone:_____ Cell Phone:_____ Home Phone:_____

Name:_____ Relationship: _____

Day Phone:_____ Cell Phone:_____ Home Phone:_____

INSURANCE INFORMATION

Please provide us w/a copy of your card

Primary Insurance Company_____ Secondary Insurance Company_____

Copay_____ Deductible_____ Copay_____ Deductible_____

ID #_____ ID #_____

Group_____ Group_____

Name of Subscriber_____ Relationship to Insured_____

Dermatology and Cosmetic Care has agreed to bill your insurance company for medical services as a courtesy to you. This does not imply a guarantee of coverage or eligibility. This form authorizes release of information necessary to secure the payment of benefits. I agree to pay for today's services in the event of non-payment by my insurance company. I understand that I am financially responsible for my medical care. I further understand that any cosmetic procedures or skin care products are payable at the time of service.
I acknowledge review of the privacy practices (HIPPA Order #HE-3) posted in this office.

Signature X_____ **Date**_____

Whom may we thank for referring you to our office?_____

Patient Name: _____ **Year:** _____

Dermatology & Cosmetic Care -- Medical Questionnaire

Current Medications (Please List):

_____
_____
_____
_____
_____

Allergies to Medications (Please List):

_____
_____
_____
_____
_____

Pregnant ☐ Breast Feeding ☐

Medical History

- ☐ Headaches
- ☐ Acne
- ☐ GERD/Reflux
- ☐ Gout
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritic Conditions
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Clots
- ☐ Fibromyalgia
- ☐ Bowel Problems
- ☐ Cancer_____
- ☐ Cardiac
- ☐ Cholesterol
- ☐ Cortisone Usage
- ☐ Crohn's Disease
- ☐ Dermatitis
- ☐ Diabetes
- ☐ Eye Conditions
- ☐ Heart Disease
- ☐ Transplant
- ☐ Hepatitis
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Herpes
- ☐ History of Miscarriages
- ☐ Hypertension
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lupus
- ☐ Skin Conditions
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Psychiatric
- ☐ Pacemaker
- ☐ Psoriasis
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Skin Cancer
- ☐ Other

Family History

- ☐ Adopted
- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Heart Problems
- ☐ Hypertension
- ☐ Lupus
- ☐ Peptic Ulcer Disease
- ☐ Psoriasis
- ☐ Renal Disease
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seizures
- ☐ Skin Cancer
- ☐ Spinal / Back Problems
- ☐ Stroke
- ☐ Other

Social History

Smoking

- ☐ Never
- ☐ Former Smoker
- ☐ Cigarettes
- ☐ Other Tobacco

Alcohol

- ☐ Never
- ☐ Occasional
- ☐ One Drink a Day
- ☐ More than 1 Drink

Blood Thinners

- ☐ Aspirin Use
- ☐ Advil / Motrin / Aleve Use
- ☐ Other Blood Thinners

Surgeries

_____
_____
_____
_____

Review of Systems

- ☐ Back Pain
- ☐ Blurred Vision
- ☐ Burning with Urination
- ☐ Change of Color of any Extremity
- ☐ Chest pain
- ☐ Cough
- ☐ Dry Eyes
- ☐ Dry Mouth
- ☐ Fevers
- ☐ GI Symptoms
- ☐ Hair Loss
- ☐ Headaches
- ☐ Joint Pain
- ☐ Loss of Bowel or Bladder Control
- ☐ Loss of feeling in Arms and legs
- ☐ Loss of Vision
- ☐ Mental Status Changes
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Pink Eye
- ☐ Skin Rash
- ☐ Stiffness
- ☐ Trouble Swallowing
- ☐ Ulcers

Are you interested in any Cosmetic information?

- ☐ *Botox*
- ☐ *Peels*
- ☐ *Restylane*
- ☐ *Laser*
- ☐ *Retin-A*

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your successful treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information and Financial form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE; UNLESS PRIOR ARRANGEMENTS ARE MADE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND ATM. ALL RETURNED CHECKS WILL BE ASSESSED A $25.00 ADDITIONAL CHARGE.

Regarding Insurance

For insurance plans in which we are a participating provider: All co pays and deductibles are due at the time of service. Please check with your insurance company to see if this facility is part of your health plan.

If for any reason your insurance company has not remitted proper payment within 45 days, you will be responsible for payment in full. Please keep in mind that the doctor does not have a contract with your insurance company, therefore; it is your responsibility to assure payment is rendered. Also be aware that some, and perhaps all, services provided may not be "covered" services and are considered "reasonable and necessary" under your insurance policy.

For all patients where we are not a participating provider: You will be given a super bill to submit to your insurance company for possible reimbursement.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients as well as charging reasonable and customary rates for our area. You are responsible for payment regardless of the insurance determination of "usual and customary" rates.

Please let us know if you have any questions or concerns.

I have read the financial policy. I understand and agree to this Financial Policy.

x_____

Signature of responsible party/patient Date

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MEDICAL & COSMETIC INTEREST QUESTIONNAIRE

Name: _____

Date: _____

(Please Circle)
new patient/returning visit

Reason for Today's Visit:_____

_____

_____

Symptoms (Circle all that apply) **PAINFUL / ITCHING / GROWING / IRRITATED / INFECTED**

Duration:_____

Medications Tried:_____

_____

Date of Last Total Skin Exam:_____

Allergies:_____

_____

Pregnant (circle one) YES NO

How far along:_____

HEALTH ISSUES OF INTEREST TO YOU

(Please X all that applies)

_____BOTOX/ DYSPORT Cosmetic
(Botulinum Toxin Type A)
_____Fillers: Juvederm/ Radiesse/ Restylane
_____Skin Rejuvenation/ Lasers
_____Retin-A or Renova
_____Micro-dermabrasion
_____Acne
_____Chemical Peels
_____Spider vein Treatments

_____AHA and Glycolic Peels
_____Skin Care Products
_____Birthmarks
_____Liver spots/ Age spots
_____Sunscreen advice
_____Removing leg veins
_____Hair removal
_____Removing facial veins

Other, Please specify_____

_____

_____

_____

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this practice, but the information in the medical record belongs to you. The law permits us to use and disclose your health information for the following purposes:

1. **Treatment:** We use medical information about you to provide you medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. **Payment:** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. **Health Care Operations:** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share you medical information with our "business associated" such as our billing service, that perform administrative services for us, or our accounting firm in order to meet appropriate bookkeeping requirements for tax reporting purposes. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law, all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share you information with other health care providers, healthcare clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professional, their training programs, their accreditation, certification or licensing activities or their health care fraud and abuse detection and compliance efforts.
4. **Appointment Reminders:** We may disclose your Medical information to contact and remind you about appointments by mail or phone. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. **Sign in sheets:** We may disclose your medical information by having you sign in when you arrive at our office, or also when we call out your name when we are ready to see you.
6. **Notification and Communication with family:** We may disclose your medical information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health care professionals will use their best judgment in communication with your family and others.
7. **Marketing:** We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.
8. **Required by Law:** We may disclose your medical information as required by law but we will limit our use of disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirements set forth below concerning those activities.
9. **Public Health:** We may disclose your medical information as sometimes required by law to health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; or reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
10. **Health oversight activities:** We may disclose you medical information as sometimes required by law, to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
11. **Judicial and administrative proceedings:** We may disclose you health information as required by law in the course of any administrative or other judicial proceedings to the extent expressly authorized by a court, administrative order, subpoena, discovery request, or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
12. **Lawful enforcement:** We may disclose your medical information as sometimes required by law to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and for law enforcement purposes.
13. **Coroners:** We may disclose your health information as often required by law, to coroners in connection with their investigations of death.
14. **Organ or tissue donation:** We may disclose your health information or organizations involved in procuring, banking or transplanting organs and tissues.
15. **Public safety:** We may disclose your health information as sometimes required by law to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
16. **Specialized government functions:** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
17. **Worker's compensation:** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent you care is covered by workers compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
18. **Change of Ownership:** in the event that this medical practice is sold or merged with another organization, your health information record "PHI" will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

B. When This, Medical Practice May Not Use or Disclose Your Health Information

Except as described in the Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. **Your Health Information Rights:** ***You have a right to:***

- **Obtain a paper copy of this notice of information practices upon request, at any time.**
- **Inspect and copy your health record.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access psychotherapy notes, you have a right to have them transferred to a mental health professional.
- **Amend or supplement:** You have a right to request that we amend your health information if you believe your health information is incorrect or incomplete. You must make a request to amend in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do now have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement of item you believe to be incomplete or incorrect.
- **Right to an accounting of disclosures:** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1(treatment), 2(payment), 3(health care operations), 6(notification and communication with family) and 16(specialized government functions of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
- **Right to request Confidential Communications:** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
- **Right to request Special Privacy Protections:** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
  If you have any questions in regards to this notice, please contact our office and ask to speak with a Privacy Officer.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this privacy policy in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created of a revised privacy policy and will be made available to patients upon request as well as be displayed in the waiting room at our information center.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer.

If you are not satisfied with the manner in which this office handles a complaint you may submit a formal complaint to:
Dept. of Health and Human Services: Office of Civil Rights
Hubert H. Humphrey Bldg
200 Independence Ave. S.W.,
Room 509F HHH Building
Washington, DC 20201
You will not be penalized for filing a complaint.

HIPAA
Notice of Privacy Policies

Judith B. Romero, M.D.

Dermatology & Cosmetic Care
Board Certified Dermatologist

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