MedDerm Associates Office of Dermatology

Financial Policy

A new patient evaluation and exam can range from $185 to $215. This includes skin exam, establishing permanent medical records, documenting medical history, prescribing medications or therapy and requesting records from previous physicians. The costs of procedures and subsequent visits can vary greatly depending on services performed. For cash patients, follow-up visits will cost $85-$150 depending on provider.

All co-pays and outstanding bills are due at time of service.

Your insurance policy is a contract between you and your chosen insurance company. We bill your insurance company as a courtesy to you when we are provided with current and correct insurance information and assignment of benefits. If your insurance requires a co-pay, it must be paid at time of service. We attempt to contact your insurance company two days prior to your initial visit to verify your insurance and deductible status. If your deductible has not been met, you may be required to pay toward your deductible at time of service. Additionally, if we are unable to obtain correct insurance information from you two days prior to the visit, you will be required to pay for your skin evaluation at the time of service. We accept cash, checks, Visa, AMEX, MasterCard, and Discover. There is a $20 return check fee.

I _____, acknowledge that MedDerm Associates Inc. will bill the insurance company that I have provided information about as a courtesy to me. I acknowledge that if, **for whatever reason**, my insurance company denies payment for a procedure or service provided to me by MedDerm Associates, **I am ultimately responsible for my medical bills and any payments due.**

_____ _____

*Signature Date

Parking

We do not validate parking unless the office visit is more than 2 hours duration.
Parking below the building is $3.00/Hour.

Labs

Most diagnostic tests and labs are an additional cost and are billed separately by the outside lab or establishment that performs them.

HIPAA Privacy Policy

I acknowledge that I can request a copy of the Notice of Privacy Practices that MedDerm Associates, Inc. has implemented. I acknowledge that MedDerm Associates, Inc. will keep a record of the health care services they provide for me. I may see and copy that record, and I may ask to correct the record if need arises. I am aware that MedDerm Associates, Inc. may disclose my health information to a physician or healthcare provider providing treatment to me, or to my insurance company to obtain payment for services. I acknowledge that MedDerm Associates, Inc. will not disclose any of my records unless I direct them to do so or unless the law authorizes or compels them to do so. I am aware that I may see my record or get more information about it by contacting: MedDerm Associates, Inc., 3965 5th Avenue Suite 200, San Diego, CA 92103, Tel# 619-542-0013. **By my signature below, I acknowledge receipt and acceptance of this Notice of Privacy Practices.**

_____ _____

*Signature of patient or authorized representative. Date

_____ _____

Printed name of representative signing on behalf of patient Relationship to patient

AUTHORIZATION FOR MEDICAL TREATMENT AND THE PERFORMANCE OF MINOR SURGERY AND/OR PROCEDURES

I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional kenalog (cortisone), *should any of these be deemed advisable, desirable, or necessary* for diagnostic, therapeutic, or investigational purposes by a physician of MedDerm Associates, for or upon me or my minor.

I further consent to laboratory examination for diagnostic, investigational purposes, and disposal by authorities of the above named medical facility or its designates herein, of any tissue or parts which may be removed.

I understand that the skin biopsy involves removal of a piece of skin and that such removal may result in a permanent scar or in discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy could be necessary during this visit.

I understand that all specimens removed are sent for dermatopathologic analysis and that the charges for dermatopathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all of the charges.

I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses may be deemed necessary by a physician at MedDerm Associates to prevent the risk that these lesions evolve into Squamous Cell Carcinomas.

I understand that the destruction by liquid nitrogen or electrocautery of warts or mollusca or keratoses or glands may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, they should be treated. Should a physician at MedDerm recommend destruction of these lesions by liquid nitrogen, I consent based on that advice. I am aware that these lesions may require more than a single treatment.
I understand that the injection of triamcinolone (cortisone) for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable or desirable by a physician at MedDerm.

Photographs may be taken during your office visit for diagnosis, treatment and surveillance purposes. All photographs are stored in our secure database. Any non-clinical use of photographs is expressly prohibited by MedDerm Associates.
Photographs are a mandatory part of comprehensive dermatologic evaluation and therapy, and individuals that decline clinical skin photography compromise their medical evaluation, and cannot be followed by MedDerm Associates.
I agree to surveillance photography stored by MedDerm Associates in the electronic medical record.

I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.
I CERTIFY THAT I HAVE READ, FULLY UNDERSTOOD THE CONSENT, AND THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS, AND MY QUESTIONS HAVE BEEN ANSWERED.

Patient Name (Please Print Clearly) _____

Signature of Patient_____ **Date:** _____

If patient is under age 18 or unable to authorize consent:
Signature of *Parent or Legal Guardian*_____ **Date:** _____

MedDerm Associates Office of Dermatology

PATIENT INFORMATION

Please write CLEARLY and include any apt. #'s, etc.., * Required information

Today's Date: _____

***First Name:** _____ ***Date of birth:** _____

***Last Name:** _____ **Marital Status:** □ S □ M □ W □ D □ DP

"AKA" or Nickname: _____ **Occupation:** _____

***Sex:** □Male □Female □Transgender Male □Transgender Female □Undifferentiated □Unknown

***Phone#1:** _____**Mobile\Home\Work** **Phone#2:** _____**Mobile\Home\Work**

***Race :** White/Black /Asian/Pacific Islander/American Indian or Alaska Native/(REFUSE TO REPORT)

***Ethnicity:** Hispanic\Latino Non-Hispanic Latino (REFUSE TO REPORT) ***Language:** _____

***Email:** _____ ***SS#:** _____
(Used for online Portal)

***Street Address:** _____**Suite/Apt:** _____

***City, State, Zip Code:** _____

***Emergency Name:** _____ **Phone:**_____ **Relationship:**_____

* **Preferred Method of Contact :** □ Secure Web Portal (recommended) □ Phone 1 □ Phone 2 □ Email (not secure)

Primary Care/Referring Physician (Name & Phone#):_____

PHARMACY INFORMATION

* **Name:** _____ * **Phone:** _____

* **Street Address:** _____

***ASSIGNMENT OF BENEFITS(eRx):** I authorize MedDerm Associates to electronically send my prescriptions to my preferred pharmacy. My medication history and prescription benefits may be downloaded into my chart from an Rx clearinghouse. This is needed for electronic prescriptions.

_____ ☐ No, thank you.

***Signature of patient or authorized representative**

MEDICATIONS AND MEDICATION ALLERGIES

Please list all of your oral and topical medications. Include over the counter medications that you use regularly, vitamins, minerals, herbal and other dietary supplements: _____

Allergies to Medications (pills, injectable drugs, creams, etc): _____

GENERAL MEDICAL HISTORY

Please list medical problems, illnesses, and major diagnoses surgeries and other procedures.

DATE	PROBLEMS, ILLNESSES AND MAJOR DIAGNOSES	SURGERIES AND OTHER PROCEDURES

PERSONAL SKIN HISTORY

*** Please circle Y or N**

Y N	**Actinic keratosis ("precancer")**	**Y N**	**Melanoma**
Y N	**Acne**	**Y N**	**Squamous Cell Carcinoma**
Y N	**Basal Cell Carcinoma**	**Y N**	**Rosacea**
Y N	**Excessive hair growth**	**Y N**	**Rheumatoid arthritis**
Y N	**Excessive sweating**	**Y N**	**Pigmentary problems**
Y N	**Eczema**	**Y N**	**Psoriasis**
Y N	**Hair loss**	**Y N**	**Lupus erythematosus**
Y N	**Keloid scarring**		

SOCIAL HABITS

*Tobacco history: Current every day smoker\Current some day smoker\Former smoker\Never smoker

*Alcohol use: □ NO □ YES: Amount _____ Frequency_____ Quit _____

*Other drugs: □ NO □ YES: Marijuana _____ Methamphetamine _____ Other _____

FAMILY HISTORY

Is there a family history of the following conditions:

Condition	Mother	Father	Grandmother Paternal	Grandmother Maternal	Grandfather Paternal	Grandfather Maternal	Brother	Sister	Aunt	Uncle
Y N Actinic keratosis ("precancer")										
Y N Acne										
Y N Basal Cell Carcinoma										
Y N Excessive hair growth										
Y N Excessive sweating										
Y N Eczema										
Y N Hair loss										
Y N Keloid scarring										
Y N Melanoma										
Y N Squamous Cell Carcinoma										
Y N Rosacea										
Y N Rheumatoid arthritis										
Y N Pigmentary problems										
Y N Psoriasis										
Y N Lupus erythematosus										

Other Family History (skin or general):_____ Family Member: _____

***CURRENT SKIN PROBLEM(S) - Reason for visit?**

1. _____
   Length of time (with issue) _____
   Site _____
   Past treatment _____
   Severity_____
   Other _____

2. _____
   Length of time (with issue) _____
   Site _____
   Past treatment _____
   Severity_____
   Other _____

REVIEW OF SYMPTOMS

Are you having problems in these areas currently?

Allergic	Yes/No
Bleeding	Yes/No
Breathing	Yes/No
Heart	Yes/No
Weight Loss/gain	Yes/No
Fevers, chills, sweats	Yes/No
Thyroid/other endocrine	Yes/No
Eye	Yes/No
Stomach (GI)	Yes/No
Female reproductive organs	Yes/No
Male reproductive organs	Yes/No
Joint/Back/Neck	Yes/No
Neurologic	Yes/No
Mood/Psychiatric	Yes/No
Ears/Nose/Throat	Yes/No
Other	Yes/No

CLINICAL TRIAL OPPORTUNITIES

What is a clinical trial?
A clinical trial is a research study of the safety and effectiveness of a therapeutic agent using consenting human subjects.

Why should I participate in a clinical trial?
Clinical trials are conducted to learn new ways to diagnose, prevent, treat or cure disease. Treatments can be new drugs or combination of drugs, surgical procedures or devices, or new ways to use existing treatments. People participate for a variety of reasons: to receive the newest treatment, contribute to moving science forward and to offer hope for cures of difficult diseases. Clinical trials compensate you for time and travel.

MedDerm is involved in clinical research trials aimed at advancing and refining dermatologic therapeutics.

Who should I contact if I'm interested?
Clinical Research Team
Phone: 619-243-7015
Email: clinicaltrials@medderm.net

Would you (or your child, or someone you know) like to be contacted for clinical trials?

☐ Yes, Full name: _____ Date of birth: _____

Phone Number/Email: _____

Interested in participating in one of the following trials:

☐ Psoriasis
☐ Acne
☐ Actinic keratosis
☐ Lupus
☐ Hidradenitis suppurativa
☐ Eczema
☐ other_____

Please hand this sheet to our receptionist.

☐ No, thank you.