Renewal Dermatology and Laser, APMC
10870 Brockway Rd
Truckee, CA 96161
Tel 530-550-0440 Fax 530-582-8853
www.renewalderm.com

PATIENT REGISTRATION FORM

Patient Name (as it appears on insurance card): (PLEASE PRINT)

_____ ❑ Jr. ❑ Sr.
First Middle Last

Nickname: _____ Date of Birth: _____ /_____ /_____ Sex: ❑ M ❑ F

Mailing Address: _____
P.O. Box City State Zip

Physical Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____ S. S. # _____/____/_____

Communication Preference (Circle): Cell Home Work

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Parent / Legal Guardian Name(s):_____

Employer: _____ Work Phone: (_____) _____-_____ ext._____

Employer Address: _____

How did you hear about our practice? _____

Insurance Information: Do you have health insurance? ❑ Yes ❑ No

Name of Insured (Guarantor/Primary Insured): _____ Guarantor Date of Birth: __ /___/____

Relationship to Patient: _____ Phone: (_____) _____-_____

Primary Insurance Carrier: _____

Secondary Insurance Carrier _____

I, the undersigned (patient or legal guardian), authorize medical treatment by Renewal Dermatology & Laser, APMC and assume financial responsibility for any service not covered by my insurance company.

Patient/Legal Guardian Signature: _____ Date: ____/____/____

Patient/Legal Guardian Print Name: _____

Email address_____

Note: Your email will allow you access to our patient portal. It will NOT be used for marketing purposes.

RENEWAL
DERMATOLOGY & LASER, APMC

History and Intake Form

Patient Name: _____ Date: _____
Ht: _____ Wt: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
GERD
Coronary Artery Disease
Depression
Diabetes
Renal Disease
High Cholesterol
Hearing Loss
Hepatitis A, B or C
High Blood pressure
HIV/AIDS
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement Location:_____
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver Surgery
Liver Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
Prostatectomy (Prostate Removed)
Spleenectomy (Spleen Removed)
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Cold Sores
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Genital Herpes
Precancerous (Atypical) Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

List dates and locations of skin cancers: _____
Anything else we should know about? _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Medications: (Please enter all current medications and dosages)
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently smoke
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Other_____

Family History (Only first degree relatives: parents, siblings, children)
_____

Review of Systems: Are you currently experiencing any of the following?
Please circle yes or no for the following:
Scarring problems: Yes No
Bleeding/bruising problems: Yes No
Healing problems: Yes No

ALERTS: (please circle all that apply)
Latex allergy
Allergy to adhesive/tape
Allergy to lidocaine local anesthetic
Rapid heart beat with epinephrine
Allergy to topical antibiotics (Polysporin/Neosporin)
Artificial heart valve
Artificial joint replacement
Blood thinners
MRSA
Pacemaker/ Defibrillator
Require antibiotics prior to a surgical procedure
Females: Are you pregnant or currently trying to get pregnant? Breast-feeding?

Immunizations:
Influenza vaccine date: _____
Pneumococcal pneumonia date: _____

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Patient Financial Responsibilities

Medicare Patients:

We (Renewal Dermatology and Laser, APMC) are a Medicare participating provider and will bill medical charges to Medicare and Medigap insurance carriers for you.

You are responsible at the time of service for payment of:

- Copayments
- Fees for non-covered or cosmetic services (You will be asked to sign an Advance Beneficiary Notice of Noncoverage in the event that a provided service is not covered by Medicare. Examples of non-covered services are: removal of benign lesions such as skin tags and cysts.)

When your billing statement is received, you are responsible for payment of:

- Annual deductibles
- Copayments not collected at the time of service
- Charges for non-covered or cosmetic services not collected at the time of service.

If you have secondary or supplemental commercial insurance that is not Medigap or with whom Renewal Dermatology and Laser is not contracted, we will file a claim for you. If no payment is received from your secondary/supplemental carrier within 60 days, you will be sent a bill and are responsible for the balance.

Note: Skin exams are not billable as a preventative visits with Medicare. Skin exams are considered part of your physical exam with your primary care provider. We bill skin exams as a regular office visit.

Patients with Insurance with which Renewal Dermatology and Laser, APMC is contracted:

Due to the many insurance plans and networks available that change constantly, it is impossible for us to always know what your insurance covers. It is your responsibility to know if we are a contracted in- network provider for your insurance and if you need prior authorization from your primary care provider to see a specialist. You are also responsible for knowing what your coverage for dermatology visits and treatments are. We will bill your insurance carrier for all medical charges based on the information you give us. Please ensure the information you give us is up-to-date and accurate to make sure the billing process goes as smoothly as possible.

Note: Skin exams are not billable as a preventative visits with most insurance plans. A skin exam is considered part of your physical exam with your primary care provider. We bill skin exams as a regular office visit.

You are responsible at the time of service for payment of:

- Copayments
- Fees for non-covered or cosmetic services. (You will be asked to sign a Cosmetic Waiver in the event that a provided service is likely to be considered "not medically necessary" and therefore not covered by your insurance. Examples of possible non-covered services are: removal of benign lesions such as skin tags and cysts.)

When your billing statement is received, you are responsible for payment of:

- Annual deductibles
- Copayments not collected at the time of service
- Charges for non-covered or cosmetic services not collected at the time of service.

Patients without Insurance or having Insurance that Renewal Dermatology and Laser, APMC, is not contracted with:

You are responsible at the time of service for payment in full.

- All fees will be charged at the discounted "Self Pay Rate".
- We will provide you with the necessary paperwork to submit to your insurance if appropriate.

Watland Billing

We use a billing service, Watland Billing, to submit charges for insurance. They can be contacted at 1-877-747-5050 if any questions arise regarding billing.

Your signature below signifies that you, the patient (or legal guardian), understand your financial responsibilities regarding charges incurred in this office.

Patient/Legal Guardian Signature: _____

Patient/Legal Guardian Print Name: _____

Date: _____

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Cancellation Policy

Renewal Dermatology and Laser, APMC, charges a cancellation fee for ALL missed appointments. If you are unable to keep your appointment, please call the office as soon as possible, so that we may help another patient in your place. If you are calling after hours, you may leave us a message on our voice mail system to cancel or reschedule your appointment.

Missed appointments (including those cancelled within 24 hours of the scheduled appointment time) will be charged a $25 missed appointment fee.

Missed extended appointments (over 15 minutes) including, but not limited to, treatments such as Levulan Photodynamic Therapy, excisions, laser and filler may be charged a $50 missed appointment fee.

Your appointment time is reserved exclusively for you. Please be considerate of others. If you miss your appointment or cancel at the last minute, we are unable to care for another patient in your place.

If you are late for your appointment, we may not be able to accommodate you and we may need to reschedule your visit. If you think you will be late for your appointment, please call us as soon as possible, so that we may advise you whether your late arrival can be accommodated or rescheduling is needed.

We make a sincere attempt to see you on time for your appointment. However, unexpected emergencies can occur and sometimes cause unavoidable delays in our schedule. If this happens, we will notify you and give you a choice of staying or rescheduling without penalty.

Your signature below signifies that you understand our Cancellation Policy and your responsibility regarding charges incurred as a result of failing to comply.

Patient/ Legal Guardian Signature: _____

Patient/Legal Guardian Print Name: _____

Date: _____

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Receipt of Notice of Privacy Practices Written Acknowledgement Form

I have read a copy of Renewal Dermatology and Laser, APMC's Notice of Privacy Practices.
I understand that a copy will be given to me upon my request.

Patient/Legal Guardian Signature: _____

Patient/Legal Guardian Print Name: _____

Date: _____

COMMUNICATION PREFERENCE

Phone number to call with medical information: _____ **Cell Home Work**

May we leave a message with personal medical information on this number? **Yes / No**

Do you give our office permission to discuss medical information with family members? **Yes / No**

If yes, please provide their names below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

EMERGENCY CONTACT

In case of emergency, whom should we notify? Name: _____

Phone Number: _____ Relationship: _____

PREFERRED PHARMACY: _____

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PRIVACY POLICIES

It is the policy of our practice that all staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and our staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and staff will:
    - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and staff respect the patient's individual dignity at all times. Our practice and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and staff will:
    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements.
    - Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and staff will:
    - Permit patients' access to their medical record when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
    - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.

- All staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

DISCRIMINATION IS AGAINST THE LAW

Renewal Dermatology and Laser, APMC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, Renewal Dermatology and Laser, APMC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Renewal Dermatology & Laser, APMC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English such as:
    - Qualified Interpreters
    - Information in other languages

If you need these services, contact Suzanne Chase, Practice Manager.

If you believe that Renewal Dermatology and Laser, APMC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Suzanne Chase, Practice Manager at Renewal Dermatology and Laser, APMC, 10870 Brockway Road, Truckee, CA 96161, Tel: 530-550-0440, Fax:530-582-8853, email: office@renewalderm.com You can file a grievance in person or by mail. Fax, or email. If you need help filing a grievance, Suzanne Chase, Practice Manager is available to help you.

You can also file a civil rights complaint with the U. S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HH Building, Washington, D.C. 20201, Ph: 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at

http://www.hhs.gov/ocr/office/file/index.html.