Patient Registration Form

____New Patient ____Other

Patient Information

First Name: ______________________________ Last Name: ________________________________ Middle:______________

Mailing Address: ____________________________________ City:_____________________ State: ______ Zip:__________

Home Phone: ______________________ Mobile Phone: ______________________ Work Phone: ____________________

(Can we leave medical messages with these numbers: ____YES ____NO)

DOB: _______________________________ Sex: ______ Male ______ Female SSN: _________________________

E-Mail Address: ____

Race:
(Circle One)

Caucasian (White)	Native Hawaiian
African American	Native American
American Indian	Native Alaskan
Asian	2 or More Races

Ethnic Group:
(Circle One)
Hispanic or Latino
NON-Hispanic or Latino

Emergency Information

Emergency Contact Name: ____

Mailing Address: _____________________________________ City:_____________________ State: ______ Zip:__________

Home Phone: ______________________ Mobile Phone: ______________________ Work Phone: _____________________

Do you give our office permission to discuss your medical information with this person? YES NO (Circle One)

Patient Pharmacy Information

Pharmacy Name: ____

Mailing Address: ____________________________________ City:_____________________ State: ______ Zip:__________

Phone: Number: ________________________________

Patient Primary Care Provider

Providers Name: ____

Mailing Address: ________________________________ City:__________________ State: ______ Zip:_________

Office Phone: ___________________ Office Fax: ___________________

Patient Medical Information

Do you have any known allergies: ____YES ____NO

If yes, please explain: ____
____

Do you have any known allergies to Medications, Latex, Ointments, Creams or Lotions: ____YES ____NO

If yes, please explain: ____
____

Medications currently taking: ____
____
____
____

Are you Pregnant or Nursing: ____YES ____NO Are you on Blood Thinners: ____YES ____NO

Patient Social History

Do you **DO** the following:

Cigarette / Cigar Smoking: ____NEVER Smoked ____Smoke Daily ____Quit Smoking

Alcohol Use: ____ NONE ____**MALES**: 5 or more drinks at a time ____**FEMALES**: 4 or more drinks at a time

Do you do **HAVE** the following:

Do you have a WILL Plan: ____YES ____NO Pneumonia Vaccination: ____YES ____NO

Patient History Information

(Circle all that apply)

Any of the following:		**Skin Disease:**
Anxiety	Hepatitis	Abnormal Moles
Arthritis	HIV/AIDS	Acne
Asthma	High Blood Pressure	Actinic Keratoses
Atrial Fibrillation	High Cholesterol	Basal Cell Carcinoma
Autoimmune Disease	Irregular Heartbeat	Blistering
Blood Clotting	Liver Disease	Eczema
Bone Marrow Transplant	Leukemia	Hair Loss
Breast Cancer	Lung Cancer	Itching Scalp
Colon Cancer	Lymphoma	Psoriasis
COPD	Poison Ivy	Squamous Cell Skin Cancer
Depression	Prostate Cancer	
Diabetes	Prostate Enlarged	History of Melanoma : ____YES ____NO
Gastric Reflux	Renal Disease	***If YES***
Hay Fever	Seizures	____Self ____Family
Hearing Loss	Stroke	(Parents, Grandparents, Siblings)
Heart Disease	Thyroid Disease	

Other: ____

Tanning Salon: _____YES _____NO Do you wear Sunscreen: _____YES _____NO

Receiving Radiation: _____YES _____NO _____Prior Date(s): ___________________________________

Patient Signatures /Notice of Receipt

Cancellation / No Show Policy
Financial Policy
Arbitration Agreement
Privacy Practice & HIPAA Notice

Patient Printed Name: ____

Patient Signature: ____

Date: _________________________________

Dermatology Institute Cancellation & No Show Policy

Medical Appointments

- I understand and agree that if I am unable to keep my appointment, I must notify the office at least 24 hours in advance. This is necessary to accommodate another patient waiting for an appointment time that would otherwise not be available. I will be reminded of my appointment by email, phone, and or text 24-48 hours in advance. I will respond and notify the office by phone or email (**frontdesk@drrullan.com**) if I cannot keep my appointment.

- I understand and agree that if I do not cancel my MEDICAL appointment within 24 hours, I will be charged a $35.00 fee and also subject to losing any deposits I have made.

Cosmetic Appointments

- I understand and agree that in order to schedule a cosmetic appointment, a deposit of $100.00 would be due for fillers and lasers. A deposit between $250.00 to $500.00 would be due for time consuming multi same day procedures. This deposit will go toward your procedure.
  Your deposit will be refunded if you cancel your appointment at least 24 hours in advance.

- Surgical procedures (such as liposuction, full face phenol peel, blepharoplasty) require a deposit of 50% of the procedure paid 2 weeks in advance. This deposit is non-refundable if the procedure is not canceled within 5 working days.

Patient Name Printed: ____

Patient Signature: ____

Date : __________________________

Dermatology Institute Financial Policy

- I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for visits. This includes any medical service or visit, preventative exam or physical, lab test, pathology test, and any other screening service or diagnostic testing ordered by the physician or the physician's staff.

- Follow up visits also have co-pays that are my responsibility, as per my contract with my insurance.

- I understand and agree that it is my responsibility to know my coverage and benefits and not the responsibility of the physician or the physician's staff to know if my insurance will pay for any medical services I receive.
- I am aware that some or all services provided may not be covered by my particular insurance plan.

- I understand and agree that it is my responsibility to know if my insurance has a deductible, co-payment, co- insurance, out of network fees, limits, or any other type of benefit limitation for the medical service I receive.

- I understand that my insurance contracted co-payment or deductible percentage is due at the time of service or within 30 days of the first bill sent to me.

- I understand that I am responsible to provide my primary insurance as well as any secondary insurance at the time of service. If I fail to bring this information, I may be required to pay at the time of service or be rescheduled. If the provider or physician I am seeing is out of network, it may result in claims being denied or higher out of pocket expenses to me. I understand and agree to be financially responsible for all charges.

- I understand and agree that I will be sent to collections for any bills I am responsible for and are not paid within 90 days of the first billing. I understand I will be billed $10 late fee for every month past due date. Once I am sent to collections, I cannot be seen as a patient and services cannot be rendered.

- I UNDERSTAND THAT I NEED TO DISCUSS ANY NEED FOR PAYMENT PLANS OR PROBLEMS WITH OUR BILLING DEPARTMENT PRIOR TO THE 90 DAYS TO AVOID BEING SENT TO COLLECTIONS BECAUSE DERMATOLOGY INSTITUTE WANTS TO MAKE EVERY EFFORT TO WORK WITH ME.

Patient Name Printed: ____

Patient Signature: ____

Date : ________________________

Dermatology Institute Arbitration Agreement

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1:
Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as *to* whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by the law ofthe state ofjurisdiction, and not by a lawsuit or resort to court process except as the law ofthe state ofjurisdiction provides for judicial review ofarbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court oflaw before a jury, and instead are accepting the use ofarbitration.

Article 2:
All Claims Must Be Arbitrated: It is the intention ofthe parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out ofor in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs ofthe patient and any children, whether born or unborn, at the time ofthe occurrence giving rise to any claim. In the case ofany pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
Filing by Physician ofany action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration ofany malpractice claim. However, following the assertion ofany claim against Physician, any fee dispute, whether or not the subject ofany existing court action, shall also be resolved by arbitration.

Article 3:
Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount ofdamages sought, and the names, addresses and telephone numbers of the patient, and (ifapplicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code ofCivil Procedure§§ 1280-1295 and the Federal Arbitration Act (9 U.S.C.§§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share ofthe neutral arbitrator's fees and expenses.

Article 4:
Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5:
Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days ofsignature and if not revoked will govern all medical services received by the patient.

Article 6:
Severability Provision: In the event any provision(s) ofthis Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder ofthe Agreement enforced in accordance with the law ofthe state ofjurisdiction.
I understand that I have the right to receive a copy ofthis agreement. By my signature below, I acknowledge that I have received a copy.

Patient Name Printed: ____

Patient Signature: ____

Date : __________________________

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.