Rapaport Dermatology
OF BEVERLY HILLS
A Professional Corporation
436 N. Bedford Drive, Suite #306, Beverly Hills, CA 90210
PHONE: (310) 274-4401 FAX (310) 274-5194

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WELCOME TO RAPAPORT DERMATOLOGY

Enclosed you will find your new patient information forms. Please fill them out and bring with you when you arrive to your appointment **(you may also fax to (310) 274-5194.** You will be responsible for bringing your insurance card (or proof of eligibility from your insurance carrier) at the time of your appointment. You are scheduled for:

Date _____ *Time* _____

Due to a long waiting list of patients who desire a sooner appointment, we ask you to please call our office should you need to cancel or reschedule. If you arrive more than 10 minutes late for your initial appointment, we cannot guarantee you will be seen. We may need to reschedule you for another time.

For appointments that are 20 minutes or longer, there is a 48 hour cancellation policy with a fee of $150 if the appointment is not cancelled within a 48 hour notice. Should a patient arrive late for an appointment that is scheduled for a service of 20 minutes or more, it can jeopardize the procedure and we cannot guarantee the patient will be seen and may be charged as a missed appointment fee.

You will find **PARKING** in our building through the valet service. We apologize but *our office does not validate.* There are additional parking structures in the area which offer 1 hour free, as well as meter parking on the streets. **Please allow plenty of time to find parking when arriving to your appointment.**

The Dr.'s look forward to meeting you and serving all of your dermatologic needs. Should you have any questions or concerns prior to your appointment, please do not hesitate to give our office a call.

PATIENT INFORMATION

❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____ /____ /____

Name: _____
Last *First* *M.I.*

Ms. ❑ Mr. ❑ Mrs. ❑

Date of Birth: ____ /____ /____ Sex: ❑ Male ❑ Female Soc. Sec. _____ ____ _____

CONTACT INFORMATION:

Mailing Address _____
City *State* *Zip*

Home Phone: ( )_____ Cell Phone: ( )_____

Work/Daytime: ( )_____

E-mail address: _____

If patient is child, check relationship: ❑ Mother ❑ Father ❑ Other _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____ Date of Birth ____ /____ /____
Last *First* *M.I.*

Address: _____
City *State* *Zip*

Home Phone: ( ) _____ Cell Phone: ( ) _____

E-mail address: _____

NO HMO PLANS ACCEPTED

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name: _____

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ____ /____ /____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name: _____

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ____ /____ /____

Please present insurance card(s) an photo ID to the receptionist so copies may be made.

REFEERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ **Today's Date** ___/___/___

Other family members that are patients: _____

Referred by: _____

Primary Care Physician _____ Phone ( ) _____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? _____

Relationship: _____ Phone ( ) _____

Do you give our office permission to discuss your medical information with family members?

☐YES ☐NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): ( ) _____ Phone # (evening) ( ) _____

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

☐YES ☐NO

May we e-mail personal medical information to you?

☐YES ☐NO

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature: _____ **Date** ___/___/___

PAYMENT POLICY: Please Initial

_____ **PPO PATIENTS:** You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services. If you fail to provide proof of insurance at the day of your appointment, you will be responsible to pay at time of service and a "Superbill" will be given to you so you may submit to your insurance company for a reimbursement.

_____ **HMO PATIENTS:** We are NOT contracted with any HMO Plans. You will be required to pay for services in full at the time of your visit.

_____ **COMMERCIAL PATIENTS:** Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature: _____ **Date** ___/___/___

HEALTH INSURANCE

Generally speaking, insurance companies calculate your "Office Visit Co-Pay" separately from any office "procedures."

When you come to the doctor's office and have a minor surgery or a few spots "burned or frozen" these are classed as procedures and are processed differently than your office visit. Most people have an annual deductible that must be met (the patient must pay that amount to doctors) **before** the insurance carrier starts to pay anything for those procedures.

Most medical procedures performed in this office ARE COVERED by insurance. This does not mean they will pay anything if your deductible has not been met for the year.

We cannot know the details of YOUR INSURANCE PLAN. A simple phone call to your carrier will help you understand how your coverage works. You should ask them **a)** if you have a deductible or not **b)** how much is your deductible **c)** how much of your deductible has been met for the current year. This will help you to anticipate your financial responsibility.

It is **YOUR RESPONISBILITY** to understand how your plan works before you seek treatment in our office.

If we are contracted with your plan we will bill you the amount your contract stipulates. We cannot take responsibility if your portion is "more than you thought it would be," "no one in your office told me that" or "I didn't know that wasn't covered by my insurance."

If we are not contracted with your plan you will be billed 100% of our fees.

If for any reason you schedule an appointment that is more than 20 minutes in length, you are subject to a cancellation fee if we are notified less than 48 hours from the time of your appointment. We call our patients as a courtesy to remind them of their appointments but it is the patient's responsibility to keep track of their appointment(s) date and time.

Patient's signature: _____ Date: _____

Dermatology Medical History

Patient: _____ Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:
1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:
Have you ever had skin cancer? ☐ YES ☐ NO
Has anyone in your family had skin cancer? ☐ YES ☐ NO
Do you have a history of any specific skin diseases? ☐ YES ☐ NO If yes, _____
Do you have problems with healing ☐ YES ☐ NO
Do you develop keloids (scars) after surgery ☐ YES ☐ NO
Do you bleed easily? ☐ YES ☐ NO
Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin ☐ Other _____

Social History:
Do you drink alcohol? ☐ YES ☐ NO If YES _____ drinks per day
Do you use IV drugs? ☐ YES ☐ NO If YES, what? _____ How often? _____
Do you smoke? ☐ YES ☐ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS) ? ☐ YES ☐ NO

Please answer the following questions:
(Women) Are you pregnant? ☐ YES ☐ NO Due Date: ___/___/___
What is your occupation? _____ Hobbies? _____

Completed by: ☐ Patient ☐ Medical Assistant _____ Initials

_____ Signed by Patient ___/___/___ Date

_____ Reviewed by ___/___/___ Date

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Patient Name: **DOB:** **Date:**

Consent for Biopsy, Cryotherapy or "freezing" of a lesion

If you are seeing the doctor or the PA (physician assistant) for a skin exam and a suspicious lesion is seen, this will serve as your consent to perform a biopsy of that lesion once the practitioner has explained why it is suspicious.

I consent to all medical and biopsy procedures, including but not limited to laboratory and biologic tests and the administration of local anesthesia, which are deemed appropriate and necessary by the doctor or physician assistant. The doctor has explained the procedure to me including the following:

Complications and Risks:

- Medication Reaction
- Lumps and bumps
- Pigmentation abnormalities
- Recurring or regrowth of lesion
- Further/additional treatment may be required to completely remove the lesion, depending on the diagnosis
- Pain or discomfort
- Scarring
- Numbness
- Asymmetry

I UNDERSTAND AND ACCEPT THE FOLLOWING:
The doctor has explained to me and I understand there may be other methods, but agree to the procedure about to be done, understanding all complications and risks.

I consent to the administration of anesthetics to be applied by or under the direction of the practitioner and of the doctor and to the use of such anesthetics, as he/she may deem advisable. I acknowledge that I do not have any known risk of history of allergies or reactions to anesthesia.

I also authorize the practitioner to perform any other procedures that he/she may deem desirable in attempting to improve the condition or any unhealthful or unforeseen condition that he/she may encounter in the biopsy.

I am aware that a scar may result from any biopsy procedure and that the appearance cannot be determined prior to biopsy. I am aware of the possibility of infection, color change of skin, regrowth or recurrence of lesion.

I know that the practice of medicine and biopsies is not an exact science and therefore reputable practitioners cannot guarantee results. No guarantee or assurance has been given by anyone as to the results that may be obtained. At the descretion of the MD and/or PA,a second opinion from an outside pathology dept. may be required, which will result in seperate/additional billing to my insurance.

I agree that photographs may be taken for documentation purposes and may be used in medical lectures, and/or scientific publications. They will not be used for promotional purposes without my informed consent.

My signature below indicates that I have read and understood this consent form in its entirety, that my questions have been adequately answered, and that I allow the physician to perform the aforementioned surgical procedure.

_____ Date:_____
Patient's (or guardian's) signature

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Consent for Physician Assistant Treatment

Patient: DOB: Date:

I understand that Rapaport Dermatology employs well qualified certified Physician Assistants (PA's) who may exam me or perform routine procedures on me.

This is legal and they are well trained in the area of dermatology to do most everything a medical doctor is trained to do.

I will ask questions if I have them or reschedule to see the MD at a later / available date.

_____ _____

Patient Name Date

Patient Screening for Aerosol Transmissible Diseases (ATD)

Do you have:

A history of Tuberculosis? Yes No If yes, explain:_____

Symptoms of tuberculosis?

Productive cough (> 3 weeks):	**Yes**	**No**	**If yes, explain:**_____
Bloody sputum	**Yes**	**No**	**If yes, explain:**_____
Night sweats	**Yes**	**No**	
Fatigue	**Yes**	**No**	
Malaise	**Yes**	**No**	
Fever	**Yes**	**No**	
Unexplained weight loss	**Yes**	**No**	

Flu & Other Aerosol transmissible diseases, including pertussis, measles, mumps, rubella, chicken pox, meningitis:

Do you have:			**How long? Explain:**
Fever?	**Yes**	**No**	_____
Body aches?	**Yes**	**No**	_____
Runny nose?	**Yes**	**No**	_____
Sore throat?	**Yes**	**No**	_____
Headache?	**Yes**	**No**	_____
Nausea?	**Yes**	**No**	_____
Vomiting or diarrhea?	**Yes**	**No**	_____
Fever and respiratory symptoms?	**Yes**	**No**	_____
Severe coughing spasms?	**Yes**	**No**	_____
Painful, swollen glands?	**Yes**	**No**	_____
Skin rash, blisters?	**Yes**	**No**	_____
Stiff neck, mental changes?	**Yes**	**No**	_____

In compliance with California OSHA Title 8, Section 5199, health care facilities must pre-screen patients for aerosol transmissible diseases. Procedures are not performed on patients suspected or identified as having aerosol transmissible diseases.

Chronic Respiratory Diseases (NOT ATD's, and not considered infectious) do not disqualify a patient from treatment under California OSHA Title 8, Section 5199:

Do you have:

Asthma?	**Yes**	**No**	Chronic upper airway cough syndrome "postnasal drip?	**Yes**	**No**
Allergies?	**Yes**	**No**	Gastroesophageal reflux disease (GERD)?	**Yes**	**No**
Emphysema?	**Yes**	**No**	Chronic obstructive pulmonary disease (COPD)?	**Yes**	**No**
Bronchitis?	**Yes**	**No**	Dry cough from ACE inhibitors?	**Yes**	**No**

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OFFICE POLICY REGARDING June 28, 2012

LATE & CANCELLATION FEES

Certain services are subject to a cancellation fee if the appointment is canceled by the patient with a less than 48 hours notice, or if the patient arrives 10 or more minutes late. Keep in mind, we have reserved this time for you and have a waiting list of patients who wish and need to be seen. We do not intend for you, nor anyone else scheduled after you to be inconvenienced.

Unpaid medical bill Late Fee	$25 per month
Facials	$50
Peels, Microdermabrasion	$50
Restylane, Juvederm, Perlane	$100
Sculptra	$100
Surgeries	$100
Hair laser removal/IPL	$100
Isolaz	$100
Sclerotherapy	$100

***Certain appointments are subject to be reserved by a credit card**

When canceling one of these appointments please ask for the name of the person you talk to.

I _____

Patient signature

Agree to abide by the above policy. Date _____