CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER
Contour Your Life

TIMOTHY M. JOCHEN, MD
BOARD CERTIFIED DERMATOLOGIST

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Title: ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss.

Legal Name: _____ ( ) Jr. ( ) Sr.
First *Middle* *Last*

Date of Birth: _____ / _____ / _____ Sex: ( ) Male ( ) Female SSN: _____-_____-_____

Race:_____ Ethnicity: _____ Preferred Language: _____

Religion:_____ Occupation: _____ Employeer: _____

CONTACT INFORMATION

Mailing Address: _____
Street # *Street Name* *Apt/Unit#*

_____
City *State* *Zip code*

Home #: _____ Work #: _____ Mobile #: _____

May we email you appointment reminders, newsletters and specials, if so please provide your email:
Email Address: _____

Spouse Name: _____ Phone#:_____ Spouse's Date of Birth: ____/____/_____

EmergencyContact:_____ Phone#:_____ Relation:_____

PARENT OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name: _____ Date of Birth: ____/____/_____ Sex: ( ) M. ( ) F.
First Middle Last

Address: _____

Home #: _____ Work #: _____ Mobile#: _____

REFERRAL SOURCE

How did you hear about our practice? ( ) Physician: _____ ( ) Patient: _____

( ) Webpage: _____ ( ) Commercial ( ) Newspaper ( ) Billboard ( ) Other: _____

PATIENT PRIVACY

Do we have your permission to discuss your medical condition or allow any member of your household to schedule appointments for you?
If Yes, whom: _____ Relationship:_____

If your primary care provider is given we will be sending their office your progress notes unless asked not to:
Primary Care provider: _____

Do we have your permission to:
Leave a message on your answering machine at home? ( ) YES ( ) NO
Leave a message at your place of employment? ( ) YES ( ) NO

Contour Dermatology reminds patients of their appointments by text message, email and by phone call.
If at any time you would like to discontinue one of these communcations you may contact our office to cancel.

Patient Signature: _____ Date: _____

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MEDICAL HISTORY FORM

LABS AND PATHOLOGY

If your insurance requires laboratory specimens to be sent to specific lab, specify your preferred lab: _____
(If no lab noted we will send specimens to our normal lab and you will be responsible for all charged incurred with them.)

ALLERGIES

Are you allergic to any medications? ( ) YES ( ) NO
If yes, please list: _____

MEDICATIONS/PRODUCTS

Pharmacy of Choice: _____ Pharmacy Phone #:_____ Cross Streets: _____
Please list all medications you are currently taking (including prescriptions, over-the-counter meds, & vitamins):
Prescriptions: _____
Over-the-Counter: _____

PAST MEDICAL HISTORY

Do you drink alcohol? ( ) YES ( ) NO If yes, how many per day? _____

Do you smoke? ( ) YES ( ) NO If yes, how many per day? _____
Have you ever had or been exposed to HIV (AIDS) or Hepatitis? ( ) YES ( ) NO
Have you ever had skin cancer? ( ) YES ( ) NO
If yes, please describe: _____
Do you have a history of Melanoma? ( ) YES ( ) NO
If yes, please describe: _____
Has anyone in your family had a history of skin cancer? ( ) YES ( ) NO
If yes, please describe: _____
Do you have a history of any specific skin diseases/reactions? ( ) YES ( ) NO
If yes, please describe: _____
List any other diseases or conditions: _____
List any surgical procedures you have had in the past year: _____
Height:_____ Weight: _____

REVIEW OF SYSTEMS: Do you have now, or have you ever had any of the listed diseases or conditions:

DERMATOLOGY
( ) oily skin
( ) dry skin
( ) red or brown spots
( ) fine lines/wrinkles
( ) sun damage

GENERAL
( ) currently pregnant
( ) currently breast feeding
( ) diabetes
( ) reaction to antibiotics
( ) reaction to bandages
( ) anticoagulant daily

ENDOCRINE
( ) excessive sweating
( ) heat/cold intolerance

MUSCULOSKELETAL
( ) arthritis/joint deformity
( ) artificial joints

GASTROENTEROLOGY
( ) nausea
( ) vomiting
( ) gastro-intestinal problems

PSYCHOLOGY
( ) depression
( ) suicidal thoughts
( ) mental or physical abuse
( ) mood swings
( ) obsessive-compulsive

BLOOD/LYMPH
( ) swollen glands
( ) fatigue
( ) varicose veins
( ) easy bruising
( ) bleed easily
( ) blood clots
( ) thyroid problems

CARDIOLOGY
( ) chest pain
( ) palpitations
( ) leg swelling
( ) heart attack
( ) high blood pressure
( ) pacemaker

NEUROLOGY
( ) headaches
( ) tingling/numbness
( ) seizures/dizziness

RESPIRATORY
( ) asthma
( ) chest tightness
( ) cough/wheezing
( ) bronchitis
( ) emphysema

NOTICE TO CONSUMERS: Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322 www.mbc.ca.gov

Patient Signature: _____ Date: _____

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OPTIONAL
COSMETIC QUESTIONNAIRE

Dear Patient,

Our goal is to respond to all of our patient's needs and to provide the highest quality care. In order to provide the information on services and products you desire on the health and appearance of your skin, we invite you to complete the following questionnaire:

PLEASE CHECK ALL CONDITIONS/SYMPTOMS THAT APPLY:

( ) Brown spots on face
( ) Cellulite reduction
( ) Crease near nose/mouth
( ) Dimpled chin
( ) Excess skin above eyes
( ) Frown lines
( ) Gummy smile
( ) Lines around my eyes
( ) Lines between my eyes
( ) Lines on my forehead
( ) Lines under my eyes
( ) Looking tired
( ) Puffy eyes
( ) Red blotchy skin
( ) Sagging neckline
( ) Scarring
( ) Sunk in/hollow eyes
( ) Thin face, no cheeks
( ) Thin lips
( ) Unwanted veins
( ) Wrinkles

PLEASE CHECK ALL SERVICES/PRODUCTS THAT INTEREST YOU:

( ) Blepharoplasty
( ) Botox/Dysport
( ) Chemical Peels
( ) CoolSculpting
( ) Facial Fillers
( ) Facials
( ) Fat Transfer
( ) Hair Transplant Neograft
( ) Hair Transplant Strip Grafting
( ) IPL (Intense Pulse Light)
( ) Laser Hair Removal
( ) Laser Resurfacing
( ) Laser Treatments
( ) Lipodystrophy Treatments
( ) Liposuction
( ) Medi-Weightloss
( ) Mini Facelift
( ) Neck/Jowl Tightening
( ) Non-Invasive Fat Reduction
( ) Picoway Laser Technology
( ) Skin Care Products
( ) Tattoo Removal
( ) Ultherapy
( ) VelaShape III

PLEASE ANSWER THE FOLLOWING QUESTION ON A SCALE OF 1 TO 5 BY CIRCLING THE APPROPRIATE NUMBER:

When looking in the mirror, I believe I look younger, the same as, or older than my true age:

Younger Than		True Age		Older Than
1	2	3	4	5

What are you currently using as your skin care regimen (please list below):

( ) Cleanser/Toner: _____
( ) Sunscreen: _____
( ) Retin-A: _____
( ) Eye Cream: _____
( ) Moisturizer: _____
( ) Night Cream: _____

Patient Signature: _____ Date: _____

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FINANCIAL POLICY

Thank you for selecting Contour Dermatology and Cosmetic Surgery Center for your medical/cosmetic care. We look forward to assisting you with your health needs. In order to prevent any misunderstanding concerning your medical care, including the responsibility for payment for medical and cosmetic services provided to our patients, the following information is provided.

Insurance
Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied you will be billed and payment in full will be your responsibility and will be expected within 30 days of receipt of statement. We are currently contacted with most PPO insurance carriers such as: Medicare, Blue Cross, Blue Shield, Blue Cross/Blue Shield, Cigna, Aetna and United Healthcare, HealthNet, and PacificCare. In the event that we are not aware of a charge that is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

HMO/Managed Care Plans
Contour Dermatology does NOT accept HMO insurance plans. Patients with HMO insurance will be considered a "cash" patient and will be responsible for payment tin full at time of service. Contour Dermatology will not bill your insurance for any visit and you will not attempt to be reimbursed by your insurance company.

Medicare
We participate in the Medicare program. You are responsible for you co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of benefits. We strive to inform our Medicare patients of that will not be covered. We require you to sign an ABN (Advanced Beneficiary Notice) which lists our fee and notifies you of your financial responsibility for certain medical services.

Medicare/Medi-cal
Our office participates with Medicare, but not Medi-Cal. As a professional courtesy, we will write off the amount applied to co-insurance. However, Medi-Medi patients are responsible to pay any amount applied toward their annual Medicare deductible and for services not covered by Medicare. This means you may be billed for up to $147 for your deductible. If your deductible has not been met prior to receiving care at our office, you will be responsible for payment.

Patient Responsibility for Payment
If you do not have insurance, you are responsible for payment of all services. If we are billing your insurance you are responsible for paying of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, bounced check, collection or attorney fees.
Failure to pay will result in your account being referred to a collection agency, which may affect your credit. You must contact our collection analyst to discuss payment arrangements. Referral to a collection agency will result in you being charged a processing fee and any applicable legal fees.

- Patient will be subject to a $25.00 processing fee for returned checks.
- Patients may be subject to a $10.00 monthly service charge for non-payment of their monthly statement.
- In the event your account must be turned over to collections, a $25.00 collection fee will be added to your account.

No Show Policy
Our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. We require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance. Failure to provide our office with advance notice may result in being scheduled as the last patient of the day to avoid affecting our schedule and other valued patients.

Labs and Pathology
If your insurance requires laboratory specimens to be sent to specific lab it is your responsibly as a subscriber to know the participating labs, specify your preferred lab:_____(if no lab noted we will send specimens to our normal lab and you will be responsible for all charged incurred with them.

Biopsies, Cultures, and specimens cut, shaved, or punched will always be sent to University Dermatopathology Associates (UDPS). Skin pathology reading performed by UDPS and in office slide preparation will incur a separate fee from the initial visit/procedure. Urgent slide preparations are completed by Eisenhower Medical Center and you will be billed by them separately. As a courtesy we will forward your insurance information to these companies for billing purposes.

As a patient of Contour Dermatology, your signature below signifies that you understand this Financial Policy and you're responsibly regarding all charges incurred in this office. Furthermore, *by signing this form you as a patient of Contour Dermatology are authorizing your insurance carrier(s), to issue payment check (s) directly to Contour Dermatology for medical services rendered to yourself and/or dependents regardless of your insurance benefits coverage.*

Patient Signature: _____ Date: _____

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CREDIT CARD ON FILE AGREEMENT AND AUTHORIZATION FORM

At Contour Dermatology and Cosmetic Surgery Center, we now offer a credit card on file agreement as a convenient method of paying for the portion of services you owe after your health plan pays its portion of your claim. Your credit card information is kept confidential and secure, and charges to your card are made only after your health plan makes its payment to us. You have the option of limiting the amount that can be charged as well.

I, the undersigned, authorize and request that Contour Dermatology and Cosmetic Surgery Center charge my credit card for the balance due that my health plan identifies as my financial responsibility. This authorization relates to all charges not covered my by insurance company for services provided to be by Contour Dermatology and Cosmetic Surgery Center. My card will remain securely stored for future use by Contour Dermatology and Cosmetic Surgery Center for payments of balances due from me. This authorization will remain in effect until revoked by me in writing.

CHARGE LIMITS: Balances exceeding $_____ require verbal authorization from me. Charges under this amount require no further authorization.

CARD HOLDER INFORMATION		
NAME:		
BILLING ADDRESS:		
CITY:	STATE:	ZIPCODE:
PHONE:		

CREDIT CARD INFORMATION
CARD TYPE: ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX ☐OTHER: _____
LAST 4-DIGITS OF CARD NUMBER: (PLEASE HAVE CARD AVAILABLE FOR RECEPTIONIST)
EXPIRATION DATE: CARD IDENTIFICATION NUMBER (CVV2 CODE):

OFFICE USE ONLY		
Patient Chart Number: _____	☐ Inputted into E-Processing	Initials of Receptionist: _____

Patient Name (PRINT): _____ Date: _____

Patient Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Patient Signature: _____ Date: _____