

NAME: _____ DATE OF BIRTH: _____
LAST FIRST M.I.

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME #: _____ CELL #: _____ WORK #: _____

PREFERRED METHOD OF CONTACT: HOME CELL WORK

LEAVE A DETAILED VOICEMAIL: YES NO

RECEIVE BILLING E-STATEMENT: YES NO

EMAIL: _____ SSN #: _____

SEX: FEMALE MALE MARITAL STATUS: _____ HEIGHT: _____ WEIGHT: _____

RACE: CAUCASIAN AMERICAN INDIAN OR ALASKA NATIVE ASIAN AFRICAN AMERICAN
 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER OTHER

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATINO

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)

NAME: _____ DOB: _____ SSN: _____
 RELATIONSHIP: _____ PHONE #: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

*****PLEASE PRESENT ID AND INSURANCE CARDS AT EVERY VISIT*****

PRIMARY INSURANCE:

INSURANCE CO. _____ POLICY # _____ GRP # _____
 NAME OF INSURED _____ DOB _____ SSN _____
 RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE:

INSURANCE CO. _____ POLICY # _____ GRP # _____
 NAME OF INSURED _____ DOB _____ SSN _____
 RELATIONSHIP TO PATIENT _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby authorize that I have received a copy of Lam Dermatology's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

Signature of Patient or Legal Representative (if applicable)

Date

BENEFITS TO PROVIDER

I hereby authorize payments directly to Lam Dermatology PLLC of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract.

Signature of Patient or Legal Representative (if applicable)

Date

RELEASE OF INFORMATION

I hereby authorize release of information necessary for filing my insurance claim or filing a payment review.

Signature of Patient or Legal Representative (if applicable)

Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Lam Dermatology to use and/or disclose my protected health information as described below to:

Name and relationship to recipient(s): _____

I understand that:

- 1) THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
- 2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).**
- 3) I may revoke this authorization at any time by notifying Lam Dermatology in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.**
- 4) Lam Dermatology agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.**

Type of information to be disclosed:

- Entire Medical Record Office Chart Notes Billing Statements Laboratory Reports Pathology Reports
 Other _____

Signature of Patient or Legal Representative (if applicable)

Date

Printed Name of Patient or Legal Representative (if applicable)

Relationship to Patient (if applicable)

OFFICE POLICIES

OFFICE HOURS

Our office is open Monday through Thursday from 8:00 AM until 4:30 PM and Friday from 8:00AM until 3:30PM, excluding holidays. We typically close for lunch between 12:00 PM and 1:00 PM. In the event of a medical emergency, please go to the nearest emergency room. Prescription refills are not considered an emergency.

APPOINTMENTS AND NO-SHOW POLICY

We make every attempt to schedule patients at the earliest possible availability. Should you need to cancel or reschedule, it is very important you give us at least 24-hour advance notice so that we can offer the appointment to another patient. In an event you are running late, please contact our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule. Many of our patients have complex diagnostic problems – although our staff tries to stay on schedule, a patient’s condition may require additional time which may create delays in our schedule. We do ask for your patience and understanding in these instances.

We have a “no-show” policy in which a patient is allowed up to three (3) no-show appointments. Patients with multiple cancellations or missed appointments may be discharged from our practice.

For surgical and patch test application appointments only, any patient that fails to show or cancel/reschedule with 24-hour advance notice will be charged a \$100.00 fee. The no-show fee is billed directly to the patient and the credit card on file will be charged. This charge is not reimbursable by your insurance and must be paid prior to rescheduling the surgical or patch testing appointment at the discretion of the provider.

PRESCRIPTION REFILLS

We require the patient to request prescription refills during an office visit. For any other instances, please call at least 48 hours in advance of the need for medication. We ask that you contact your pharmacy with your request and allow the pharmacist to contact our office. Please check with the pharmacy directly to see if your refill has been approved and remember to allow two (2) business days. **No refill requests will be processed after office hours or on weekends.**

DIAGNOSTIC TESTS/LAB RESULTS

If tests are ordered by any providers within this practice, you will be contacted by telephone with the results within five (5) business days by our office. If the test was ordered or performed by another practice or physician, you should contact that office directly for your results.

You may receive a separate bill for laboratory or pathology services from an off-site lab for any tests your physician may order. Please discuss any billing errors or discrepancies with that laboratory.

FINANCIAL POLICY

All patients are required to keep a credit card on file and signed authorization to charge the card for patient balances. **Patients are responsible for payment at the time of service.** We do accept Cash, Checks, MasterCard, Visa, Discover, and AMEX. There will be a \$30.00 charge for all returned checks and a \$25.00 charge for all debit/credit card chargebacks.

Lam Dermatology is a contracted provider with many insurance plans and may accept assignment of benefits. As a courtesy, we will file all claims, including secondary insurance, to the plans with which we participate. Please inform us of any special requirements in your plan.

You are responsible to pay for any co-payments, any applicable dermatology procedures, and cosmetic treatments at the time of each visit. Most dermatology procedures go toward your deductible. Should your insurance pay these procedures in full, we will refund your payment upon receipt of your insurance payment. You are required to pay the deductible or co-insurance amounts designated by your insurance company. If your insurance company denies your bill, you will be billed directly for those services and are held financially responsible.

In the event your health plan determines a service to be “not covered” or missing authorization and/or coordination of benefits, you will be responsible for the total charge. We encourage our patients to understand their policy and to contact their insurance company for clarification of benefits prior to services being rendered. You must inform the office of all insurance changes, authorization and/or referral requirements, e-mail changes, and address changes. In the event the office is not informed before care is rendered, you will be responsible for any denied charges.

Patients with balances over \$100.00 must make payment arrangements prior to future appointments being made. Patients who have questions about their bills or would like to discuss a payment plan option may contact our billing office at (954) 852-3604.

In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent’s responsibility to collect from the other parent.

NON-VISIT RELATED FORMS

We charge **\$15 per non-visit related form** to be completed, and **without exception the money must be prepaid** at the time the form is left with our office. FMLA forms are charged at **\$40 per form**, and again, we require this to be prepaid at the time the form is left with our office. We require 5 business days to complete the forms. Patients may come by to retrieve their form, or they may provide our office with a stamped, self-addressed envelope and it will be forwarded as indicated.

- _____ (Initials) I have signed the patient Authorization for Use and Disclosure of Protected Health Information from Lam Dermatology.
- _____ (Initials) I have received Lam Dermatology’s office and financial policies.
- _____ (Initials) I have received the Appointments and No-Show Policy and agree to its terms.
- _____ (Initials) I understand any co-payments, deposits, and other applicable dermatology procedures and cosmetic treatments are due at the time of service as specified by these terms.
- _____ (Initials) With my consent, Yaohan Lam Dermatology PLLC may e-mail any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondences, and billing statements.

By signing below, I acknowledge, with my initials above, I have received, read, and understand the office and financial policies, and I agree to be bound by its terms. I understand and agree such terms may be amended in the future by the practice.

Signature of Patient or Legal Representative (if applicable)

Date

Credit Card on File Agreement

Lam Dermatology and Associates has a credit card on file requirement. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed patient’s responsibility, such as copay, deductible and co-insurance.

Co-pays are due at time of visit. At check-in, the credit card information will be obtained and kept confidential and secure until the insurance(s) have paid their portion and notifies Lam Dermatology of the balance due, if any. That amount will automatically be charged to your card after two (2) net-30-day statements have been sent to you via mail and/or e-mail. In the event that your card has reached its limit maximum, the bill will be subject to additional collection activity.

If you have any questions about the policy, please email your inquiries to info@lam-dermatology.com.

I authorize Lam Dermatology and Associates to keep my debit/credit card on file and to charge my debit/credit card for any outstanding balances that my health plan has identified as my financial responsibility.

If the provided debit/credit card has changed, expired or denied for any reason, I agree to immediately give Lam Dermatology and Associates a new, valid debit/credit card which I will allow to be charged over the phone. I agree that the new card will be used with the same authorization as the original card I presented.

| | | | |
|---|-------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Visa | <input type="checkbox"/> MasterCard | <input type="checkbox"/> Discover | <input type="checkbox"/> American Express |
| Patient’s Name (print): | | | |
| Date of Birth (mm/dd/yyyy): | | | |
| Cardholder Name (print): | | | |
| Last Four Digits of Debit/Credit Card Number: | | | Exp. Date: |
| Billing Address: | | | |
| <input type="checkbox"/> Please check this box if you prefer not to receive a statement and would like us to bill your debit/credit card immediately for any balances due after the processing of your insurance. | | | |

Debit/Credit Card Holder’s Signature: _____ Date: _____

| | |
|---|-------------|
| OFFICE USE | |
| Authorization Received by: _____ (Initials) | Date: _____ |

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

Do you have a health care proxy? Yes No If yes, please list designee's name and phone #: _____

PHARMACY: _____ PHONE: _____ ADDRESS: _____

CHIEF COMPLAINT (REASON FOR VISIT): _____

| PAST MEDICAL CONDITION(S) | PAST SURGICAL HISTORY | PERSONAL HISTORY | ALCOHOL USE |
|---|--|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Breast Mastectomy: | <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Never drink alcohol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both | <input type="checkbox"/> Squamous Cell Carcinoma | <input type="checkbox"/> Less than 1 drink per day |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Breast Lumpectomy: | <input type="checkbox"/> Melanoma | <input type="checkbox"/> 1-2 drinks per day |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both | <input type="checkbox"/> Actinic Keratoses | <input type="checkbox"/> 3+ drinks per day |
| <input type="checkbox"/> BPH (benign enlargement of the prostate) | <input type="checkbox"/> Heart: Mechanical Valve | <input type="checkbox"/> Atypical Moles | SMOKING STATUS |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Heart: Biological Valve | <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Never smoked |
| <input type="checkbox"/> Cancer, Type _____ | <input type="checkbox"/> Heart: Transplant | <input type="checkbox"/> Precancerous Moles | <input type="checkbox"/> Former smoker |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hip Replacement - Year: _____ | FAMILY HISTORY OF SKIN CANCER | <input type="checkbox"/> Smokes less than daily |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both | <input type="checkbox"/> Basal Cell Carcinoma | <input type="checkbox"/> Smokes daily |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Knee Replacement – Year: _____ | <input type="checkbox"/> Squamous Cell Carcinoma | ALLERGIES |
| <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both | <input type="checkbox"/> Melanoma | Adhesive Y N |
| <input type="checkbox"/> Hepatitis, Type _____ | <input type="checkbox"/> Ovaries (Oophorectomy) | <input type="checkbox"/> No Family History of Skin Cancer | Lidocaine Y N |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Skin: Skin Biopsy | PERSONAL HISTORY OF SUN EXPOSURE | Topical Antibiotic Ointments Y N |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin: Skin Cancer, Type _____ | Wear Sunscreen Daily? Y N | Other Medication Allergies: |
| <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Uterus (Hysterectomy) | Tan in Tanning Salon? Y N | _____ |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> None Apply to Me | ALERTS | _____ |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Other _____ | Artificial Heart Valve Y N | _____ |
| <input type="checkbox"/> Leukemia | WOMEN ONLY – PREGNANCY AND CHILDBEARING INFORMATION | Artificial Joints within 2 years Y N | _____ |
| <input type="checkbox"/> Seizures | Are you pregnant? Y N | Blood Thinners Y N | _____ |
| <input type="checkbox"/> Stroke | Are you breastfeeding? Y N | Defibrillator Y N | _____ |
| <input type="checkbox"/> None Apply to Me | Planning pregnancy? Y N | Pacemaker Y N | _____ |
| <input type="checkbox"/> Other _____ | Are you on birth control? If yes, what form? Y N | MRSA/Staph Y N | _____ |
| | | Premedication prior to procedures Y N | _____ |
| | | Rapid heartbeat to epinephrine Y N | _____ |

| CURRENT MEDICATION(S) | REVIEW OF SYSTEMS: PLEASE CIRCLE YES OR NO FOR ALL SYMPTOMS YOU ARE CURRENTLY EXPERIENCING | | | |
|---|--|---------------------------------|---------------------------------|--|
| Import Rx history from primary care physician: <input type="checkbox"/> Yes <input type="checkbox"/> No | Hematologic/Lymphatic | | Respiratory | |
| | Problems with bleeding Y N | Cough Y N | | |
| | Integumentary - Skin | | Gastrointestinal | |
| | Rash Y N | Nausea or vomiting Y N | | |
| | Allergic/Immunologic | | Persistent diarrhea Y N | |
| | Immunosuppression Y N | Tightness or abdominal pain Y N | | |
| | Constitutional | | Genitourinary | |
| | Fever, chills or shakes Y N | Rash/ulcers in genital area Y N | | |
| | Eyes | | Musculoskeletal | |
| | Pain or vision change Y N | Joint pain Y N | | |
| | Ears/Nose/Mouth/Throat | | Neurological/Psychiatric | |
| | Sores in mouth Y N | Headaches Y N | | |
| | Cardiovascular | | Dizziness Y N | |
| | Sudden onset of chest pain Y N | | | |