Alta Dermatology
For the health and beauty of your skin

Alta Dermatology Patient Registration

Name: _____ **Date of Birth:** _____
Last, First, MI

Address: _____

City: _____ **State:** _____ **Zip:** _____

Preferred Phone Number: _____

Email Address: _____ **Nickname:** _____

Do we have permission to:
Leave a detailed message on your preferred phone number? Yes □ No □

Discuss your medical condition with any member of your household? Yes □ No □

If yes, whom: _____

Relationship to patient _____ Phone Number _____

Name of Spouse (or Legal Guardian if Minor): _____

How did you hear about our office? _____

Referred by? _____

Primary Care: _____
Doctor Name City

Preferred Pharmacy: _____
Pharmacy Name Phone Number/ City

Medical Insurance:
Primary Insurance _____Secondary Insurance _____

Payment Information:
Payment is expected at the time of your visit for any co-payments, coinsurance, deductibles, unpaid Medicare or insurance and any cosmetic procedures or skin care products. We appreciate your cooperation in keeping your account up-to-date at each office visit. If there are any questions, please ask one of our team members or refer to the Financial Policy attached.

_____ _____
Signature of patient/ representative if minor Date

HIPAA Form Copy Acknowledgment (attached)
I, hereby acknowledge that I have received a copy of Alta Dermatology's "Notice of Privacy Practices"

_____ _____ _____
Print Name Signature Date

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at **https://openpaymentsdata.cms.gov**.

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Medical History Intake Form

Name: _____ **D.O.B:** _____ **Date:** _____

Past Medical History:

Do you have or have you ever had:

Anxiety	Yes	No
Arthritis	Yes	No
Artificial Heart Valve	Yes	No
Atrial Fibrillation	Yes	No
Asthma	Yes	No
Breast Cancer	Yes	No
Colitis/Crohn's	Yes	No
Coronary Artery Disease	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Renal Disease	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
HIV/AIDS	Yes	No
High Cholesterol	Yes	No
Hyperthyroid	Yes	No
Hypothyroid	Yes	No
Joint Replacement	Yes	No
Leukemia Lung Cancer	Yes	No
Lymphoma	Yes	No
Radiation Treatment	Yes	No

NONE

Other Medical Conditions: _____

_____

Past Surgeries: _____

_____

Patients 65 years & older:

Have you received your pneumonia vaccination?
☐ Yes ☐ No

Are you up to date with flu shot?
☐ Yes ☐ No

Do you have a health care proxy in the event you are unable to make your own medical decisions?
☐ Yes ☐ No

Designee's name: _____

Designee's phone number: _____

Do you have a living will?
☐ Yes ☐ No

Skin Disease History:

Do you have or have you ever had:

Acne	Yes	No
Actinic Keratoses	Yes	No
Blistering Sunburns	Yes	No
Eczema/ Dry Skin	Yes	No
Flaking or Itchy Scalp	Yes	No
Hay Fever/ Allergies	Yes	No
Psoriasis	Yes	No
Melanoma Skin Cancer	Yes	No
Basal Cell Carcinoma Skin Cancer	Yes	No
Squamous Cell Carcinoma Skin Cancer	Yes	No
Do you tan in a tanning salon	Yes	No
Do you wear sunscreen?	Yes	No

If so what SPF? _____

Family History (immediate family only):

Melanoma Yes No

If yes, whom? _____

Medications:

List ALL current medications you are taking, including any over-the-counter, herbal supplements or vitamins:

_____

_____

_____

Allergies:

Do you have any sensitivities or allergies to any medications? (Including oral medications, topical creams/ointments, etc.) If so, please list:

_____

_____

Social History:

Do you smoke ? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

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Cosmetic Interest Questionnaire

At Alta Dermatology, we provide several products and services that can protect and improve the appearance of your skin. Would you be interested in learning more?

□ Yes (If so, please indicate your interests below) □ No (Skip page & move on)

Name: _____ **Date:** _____ **D.O.B:** _____

Health Issues, procedures or products of interest to you (please check all that apply)

□ **Laser treatments:** for blood vessels, facial redness, brown spots, scars, tightening

□ **Chemical Peels:** for acne, sun spots, fine lines and skin texture

□ **Botox Cosmetics:** for unwanted lines and wrinkles between eyebrows, crows feet and forehead

□ **Dermal Fillers:** for unwanted lines, facial folds, correct age related volume loss, to create a smoother or fuller appearance and restore facial contours

□ **Sclerotherapy:** for unwanted leg veins

□ **Skin Care Products:** including sun protection, skin rejuvenation, acne regimen, anti- aging

□ **Latisse:** for longer, darker, fuller eyelashes

Other Services/ Cosmetic concerns(please specify): _____

_____

Email: _____

* Please provide your email to receive information on special discounts & promotions

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: 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 California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THIS AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN 30 DAYS OF THE DATE OF MY SIGNATURE BELOW STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www.cmanet.org. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date I intend this Agreement to be effective from as confirmed by my initials immediately below.
Earlier effective date:_____ Patient's Initials:_____ _____

ARTICLE 7: I have read and understood all of the information in this pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Sign here > _____ **Dated:** __/__/____, _____
(Signature of Patient, Parent, Guardian or Legally Authorized Representative of Patient) (Initials)

If signed by other than patient, indicate relationship:_____ _____
(Print Name) (Relationship)

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

_____ Dated: __/__/____, VW
(Physician or Duly-Authorized Representative) (Initials)

Alta Dermatology
27682 Forbes Rd Ste 201
Laguna Niguel, CA 92677

Title—e.g., Partner, President, etc. Print name of Physician, Medical Group, Partnership or Association

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In-Network Insurances

Please be advised that it is **patient responsibility** to verify that your insurance plan has eligible coverage and is in-network with Dr. Wang. As a courtesy to our new patients we will call your insurance once scheduled to verify we are in network, however in some cases the provider line at insurance companies are unavailable. If we are unable to reach the provider line, we will ask you to call the patient line to verify you are in network and ask for a reference number for the call before your appointment or you will be seen as a self pay patient until reference number is received.
We would also be happy to still see you as a self-pay patient if your plan is out-of-network.

PPO Plans in network

Blue Cross United Healthcare
Blue Shield Health Net
Aetna Cigna
Medicare

Our providers are not an in-network provider for any HMO, Covered California or Medi-Cal plans.

Please also be advised that Alta Dermatology will collect the patient portion including copays, deductibles and coinsurance of your insurance plan (based on the contracted rate with the insurance provider) at the time of service. If you have any questions, please ask prior to being seen or having procedures completed.

Statement of Commitment

At Alta Dermatology, we are committed to treating you with the utmost courtesy and respect, with appreciation of your individual dignity, in a safe setting and with protection of your need for privacy. As a patient, it is your responsibility to follow our rules and regulations, to be considerate and cooperative, and respect the rights of others. It is very important that our employees feel safe in their work environment.

Please be advised that completing preliminary health and insurance questionnaire does not establish a physician-patient relationship with our practice. We will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

Signature: _____ Date: _____

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Financial Policy

Patient Name: _____ **Date of Birth**:_____

Basic Policy: Patient payment is due in full at the time service is provided in our office.
Insurance In Network Patients: We bill most insurance carriers for you if proper insurance and identification card is provided to us. We will also bill most secondary insurance companies for you unless we are out of network. Copayments, coinsurance, deductibles and patient balances are due at the time of service. Please be advised that every insurance carrier has their own customary fee schedule. Since your agreement with your insurance carrier is private, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid, professional fees are due and payable in full from you.
Medicare Patients: We will bill Medicare for you. We will also bill secondary insurance carriers for you unless we are out of network. All copayments and deductibles are due and payable at the time service is provided.
Self Pay Patients: Patients who either do not have insurance coverage or have out-of-network insurance are considered to be self pay. Self pay patients will be required to make payment at the time of service.
Non-Covered Services/ Cosmetic Procedures: Any care not paid or not covered for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. Cosmetic procedures are elective and will not be covered by insurance. Payment will be due at the time of service.
Surgery Fees: All payments for surgical procedures are due at the time of your surgery. If multiple surgeries are needed they will need to be scheduled on all separate appointments. Dr. Wang has a strict policy of only one surgery site per day. No exceptions.
Laboratory Services: Some services, such as biopsies, cultures, or surgery require specimens be sent to a laboratory for processing. The patient may receive a separate bill from Laguna Pathology or another laboratory such as Labcorp or Quest. The patient is responsible for payment for all laboratory services not covered by insurance. It is advised that for any laboratory billing discrepancies, the laboratory be contacted directly.
Late Cancellations/ No Show Appointments: In fairness to other patients and the provider, we require at least 24 hour notice to cancel or reschedule appointments. There will be a fee for any late cancellations and no show appointments. For non-surgical appointments, there will be a $50 fee. For surgical and cosmetic appointments, there will be a $100 fee. For Mohs surgery appointments, there will be a $200 fee.

Assignment of Benefits and Rights

Assignment of Insurance Benefits: Patients with in network insurance, please read below:

I hereby assign all medical and/ or surgical benefits (to include major medical benefits to which I am entitled, private insurance, and any other health plans) to **Alta Dermatology** for medical reimbursement in accordance with the terms and benefits of the insurance policy or other health benefits. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

Your insurance card's and driver's license (or identification card) will be required at check in.

I have read, understood, and agreed to the above financial policy for payment of professional fees.

I understand that I am ultimately responsible for all professional fees.

Signature: _____ Date: _____