



**PROCEDURE PRICE LIST**

**Please note: you may disregard this notice if you are a Medicare recipient.**

Many dermatology procedures go towards your insurance deductible. Please be aware that if you have one of these procedures done, we will collect an **estimated** payment for the services listed below.

Should your insurance pay these procedures in full, we will refund your payment upon receipt of that payment. For your convenience (and because we know that no one likes a surprise) we have listed below the estimated insurance allowed amounts for the most common procedures done in this office which may go towards your deductible.

**Please note that this is an estimate only!** Unexpected additional charges could increase the amount due directly from you, or fulfillment of the payment terms could result in a credit balance should the insurance pay more than estimated. Overpayments will be cheerfully refunded and additional amounts due will be billed as appropriate.

PROCEDURE	ESTIMATE OF INSURANCE POLICY ALLOWED
Biopsy of a single skin lesion	125.00
Biopsy of each additional lesion	40.00
Destruction of actinic keratosis/precancerous lesions	100.00 – 210.00
Destruction of a wart, molluscum, or other benign lesion	130.00 – 160.00
Excision of a skin lesion-trunk, genitalia, arms, legs	175.00 – 360.00
Excision of a skin lesion-scalp, neck, hands,feet	140.00 – 240.00
Excision of a skin lesion-face, ears, eyes, nose, lips	160.00 – 460.00
Surgical repair of the above-listed lesion(s)	225.00 – 540.00

\_\_\_\_\_  
*Signature of Patient or Responsible Party*

\_\_\_\_\_  
*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 AND FINANCIAL POLICIES

Thank you for selecting our practice for your dermatological needs. Our goal is to provide you with the highest quality of treatment and service. Your complete understanding of your financial responsibilities is an essential element of your care. If you have any questions about the following policies, please do not hesitate to ask our staff.

### OFFICE HOURS

Our office is open Monday through Friday from 8:00 AM until 4:30 PM, 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

We make every attempt to schedule patients at the earliest possible opening. Should you need to cancel or reschedule, it is very important that you give us at least 24 hours' notice so that we can offer the appointment to another patient. In an event you are running late, please call our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule. Patients with multiple cancellations or missed appointments also may be discharged from our practice. Many of our patients have complex diagnostic problems – although Dr. Lam and our staff tries to stay on schedule, a patient's condition may require that we spend additional time, and that may create delays in our schedule. We do ask your patience and understanding in these instances.

### 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 2 business days. **No refill requests will be accepted or processed after office hours or on weekends.**

### DIAGNOSTIC TESTS, LAB RESULTS

If such tests are ordered by Dr. Lam or any other provider within this practice, you will be contacted by telephone with the results within 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.

### FINANCIAL POLICY

**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.

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. Many dermatology procedures go toward your deductible. **Please be aware that we collect an estimated payment on a few of these procedures at the time of check out (please refer to our Procedure Price List for details).** 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 you do not have an authorization, you may be responsible for the complete 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 referral requirements, and address changes. In the event the office is not informed before care is rendered, you will be responsible for any charges that are denied.

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.

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.

**I have read and understand the office and financial policies, and I agree to be bound by its terms. I understand and agree that such terms may be amended in the future by the practice.**

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*Signature of Patient or Legal Representative (if applicable)*

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*Date*

**I understand that all co-payments are due at the time of service as specified by these terms.**

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*Signature of Patient or Legal Representative (if applicable)*

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*Date*

Your visit today may include labs, cultures and/or skin biopsies. We generally receive results of lab work/cultures in approximately 3-5 business days and skin biopsy results in 7-10 business days. We will call you with results and any additional information prescribed by your physician. For **BENIGN / NEGATIVE** results on any tests listed above:

**YES**, you may leave a detailed message informing me of my results at the following phone #: \_\_\_\_\_  
 **NO**, do not leave a detailed message. Please leave call back information only on my voicemail.

**Primary Care Physician:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**PHARMACY:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_ **Cross Street:** \_\_\_\_\_

**MEDICAL INFORMATION**

CHIEF COMPLAINT (Reason for your visit) \_\_\_\_\_

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU:

OR  **None Apply to Me**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Anxiety                                  | <input type="checkbox"/> Colon Cancer         | <input type="checkbox"/> Hepatitis, Type: _____             | <input type="checkbox"/> Lymphoma        |
| <input type="checkbox"/> Arthritis                                | <input type="checkbox"/> COPD                 | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> Coronary Artery Dis. | <input type="checkbox"/> HIV/AIDS                           | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Atrial Fibrillation                      | <input type="checkbox"/> Depression           | <input type="checkbox"/> Hypercholesterolemia               | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Bone Marrow Transplant                   | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Hyperthyroidism                    | <input type="checkbox"/> OTHER _____     |
| <input type="checkbox"/> BPH (benign enlargement of the prostate) | <input type="checkbox"/> End Stage Renal Dis. | <input type="checkbox"/> Hypothyroidism                     | _____                                    |
| <input type="checkbox"/> Breast Cancer                            | <input type="checkbox"/> GERD                 | <input type="checkbox"/> Leukemia                           | _____                                    |
| <input type="checkbox"/> Bleeding Tendency                        | <input type="checkbox"/> Hearing Loss         | <input type="checkbox"/> Lung Cancer                        | _____                                    |

PAST MEDICAL HISTORY (other illnesses not listed above): \_\_\_\_\_

**PAST SURGICAL HISTORY**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>None Apply to Me</b>  | <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery  | <input type="checkbox"/> Ovaries (Oophorectomy): Endometriosis    |
| <input type="checkbox"/> Appendix (Appendectomy)  | <input type="checkbox"/> Heart: PTCA  | <input type="checkbox"/> Ovaries (Oophorectomy): Cysts            |
| <input type="checkbox"/> Bladder (Cystectomy)   | <input type="checkbox"/> Heart: Mechanical Valve Replacement  | <input type="checkbox"/> Ovaries (Oophorectomy): Cancer           |
| <input type="checkbox"/> Breast: Mastectomy<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Heart: Biological Valve Replacement  | <input type="checkbox"/> Prostate(Prostatectomy): Prostate Cancer |
| <input type="checkbox"/> Breast: Lumpectomy<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Heart: Transplant  | <input type="checkbox"/> Prostate(Prostatectomy): Prostate Biopsy |
| <input type="checkbox"/> Breast Biopsy  | <input type="checkbox"/> Joint Replacement – Knee<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both | <input type="checkbox"/> Prostate (Prostatectomy): TURP           |
| <input type="checkbox"/> Breast Reduction   | <input type="checkbox"/> Joint Replacement – Hip<br><input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both  | <input type="checkbox"/> Skin: Skin Biopsy                        |
| <input type="checkbox"/> Breast Implants  | <input type="checkbox"/> Kidney: Biopsy   | <input type="checkbox"/> Skin: Basal Cell Carcinoma               |
| <input type="checkbox"/> Colon Cancer Resection   | <input type="checkbox"/> Kidney: Nephrectomy  | <input type="checkbox"/> Skin: Squamous Cell Carcinoma            |
| <input type="checkbox"/> Colon: Diverticulitis  | <input type="checkbox"/> Kidney: Kidney Stone Removal   | <input type="checkbox"/> Skin: Melanoma                           |
| <input type="checkbox"/> Colon: Inflammatory Bowel Dis.   | <input type="checkbox"/> Kidney: Transplant   | <input type="checkbox"/> Spleen (Splenectomy)                     |
| <input type="checkbox"/> Gallbladder (Cholecystectomy)  |   | <input type="checkbox"/> Testicles (Orchiectomy)                  |
|   |   | <input type="checkbox"/> Uterus (Hysterectomy): Fibroids          |
|   |   | <input type="checkbox"/> Uterus (Hysterectomy): Uterine Cancer    |

OTHER: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SKIN DISEASE HISTORY**

- |  |   |  |                                    |
|--|---|--|------------------------------------|
| <input type="checkbox"/> Acne                | <input type="checkbox"/> Dry Skin               | <input type="checkbox"/> Hay fever/Allergies | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Actinic Keratosis   | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Poison Ivy          |                                    |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Precancerous Moles  |                                    |

**SKIN HISTORY**

**Personal History of Skin Cancer**

- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Melanoma
  - Unsure
  - No

**Personal History of Sun Exposure**

- Do you wear sunscreen daily?  Yes  No
- If yes, what SPF? \_\_\_\_\_
- Do you tan in a tanning salon?  Yes  No
- Multiple blistering sunburns as a child?
  - Yes  No
- History of Skin Cancer History of atypical moles?
  - Yes  No

**Family History of Skin Cancer**

- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Melanoma
- Skin Cancer, unsure which type
- No Family History of Skin Cancer

**MEDICATION HISTORY**

LIST ALL CURRENT MEDICATIONS or PROVIDE PRINTED LIST

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES**

LIST ALL ALLERGIES TO PRESCRIPTION AND NON-PRESCRIPTION MEDICINES

_____	_____
_____	_____
_____	_____

**SOCIAL HISTORY**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Never Drink Alcohol | <input type="checkbox"/> less than 1 drink per day | <input type="checkbox"/> 1-2 drinks per day     | <input type="checkbox"/> 3+ drinks per day |
| <input type="checkbox"/> Never Smoked        | <input type="checkbox"/> Quit, Former Smoker       | <input type="checkbox"/> Smokes Less Than Daily | <input type="checkbox"/> Smokes Daily      |

Name \_\_\_\_\_

Date \_\_\_\_\_

**REVIEW OF SYSTEMS AND ALERTS**

PLEASE CHECK YES OR NO IN THE BOX PROVIDED FOR ALL SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

Hematologic/Lymphatic	<input type="checkbox"/> No to All	Endocrine	<input type="checkbox"/> No to All	Gastrointestinal	<input type="checkbox"/> No to All
problems with bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes	thyroid problems	<input type="checkbox"/> No <input type="checkbox"/> Yes	nausea or vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes
swollen glands	<input type="checkbox"/> No <input type="checkbox"/> Yes	excessive thirst	<input type="checkbox"/> No <input type="checkbox"/> Yes	heartburn	<input type="checkbox"/> No <input type="checkbox"/> Yes
tender glands	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Eyes</b>	<input type="checkbox"/> No to All	increasing constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes
anemia	<input type="checkbox"/> No <input type="checkbox"/> Yes	redness	<input type="checkbox"/> No <input type="checkbox"/> Yes	persistent diarrhea	<input type="checkbox"/> No <input type="checkbox"/> Yes
transfusion	<input type="checkbox"/> No <input type="checkbox"/> Yes	pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	blood in stool or black stool	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Integumentary - Skin</b>	<input type="checkbox"/> No to All	double vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	tightness or abdominal pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
problems with healing	<input type="checkbox"/> No <input type="checkbox"/> Yes	blurred vision	<input type="checkbox"/> No <input type="checkbox"/> Yes	jaundice	<input type="checkbox"/> No <input type="checkbox"/> Yes
problems with scarring	<input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Ears/Nose/Mouth/Throat</b>	<input type="checkbox"/> No to All	<b>Genitourinary</b>	<input type="checkbox"/> No to All
easy bruising	<input type="checkbox"/> No <input type="checkbox"/> Yes	ringing in ears	<input type="checkbox"/> No <input type="checkbox"/> Yes	pain/burning on urination	<input type="checkbox"/> No <input type="checkbox"/> Yes
redness	<input type="checkbox"/> No <input type="checkbox"/> Yes	runny nose	<input type="checkbox"/> No <input type="checkbox"/> Yes	blood in urine/cloudy,	<input type="checkbox"/> No <input type="checkbox"/> Yes
rash	<input type="checkbox"/> No <input type="checkbox"/> Yes	sores in mouth	<input type="checkbox"/> No <input type="checkbox"/> Yes	smoky urine	
hives	<input type="checkbox"/> No <input type="checkbox"/> Yes	dryness in mouth	<input type="checkbox"/> No <input type="checkbox"/> Yes	discharge from penis/vagina	<input type="checkbox"/> No <input type="checkbox"/> Yes
itching	<input type="checkbox"/> No <input type="checkbox"/> Yes	frequent sore throat	<input type="checkbox"/> No <input type="checkbox"/> Yes	getting up at night to pass urine	<input type="checkbox"/> No <input type="checkbox"/> Yes
sun sensitive	<input type="checkbox"/> No <input type="checkbox"/> Yes	difficulty swallowing	<input type="checkbox"/> No <input type="checkbox"/> Yes	vaginal dryness	<input type="checkbox"/> No <input type="checkbox"/> Yes
tightness	<input type="checkbox"/> No <input type="checkbox"/> Yes	hoarseness	<input type="checkbox"/> No <input type="checkbox"/> Yes	rash/ulcers in genital area	<input type="checkbox"/> No <input type="checkbox"/> Yes
nodules/bumps	<input type="checkbox"/> No <input type="checkbox"/> Yes				
hair loss	<input type="checkbox"/> No <input type="checkbox"/> Yes				
color changes - hands/feet	<input type="checkbox"/> No <input type="checkbox"/> Yes				
<b>Allergic/Immunologic</b>	<input type="checkbox"/> No to All	<b>Cardiovascular</b>	<input type="checkbox"/> No to All	<b>Musculoskeletal</b>	<input type="checkbox"/> No to All
frequent sneezing	<input type="checkbox"/> No <input type="checkbox"/> Yes	sudden onset chest pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	morning stiffness	<input type="checkbox"/> No <input type="checkbox"/> Yes
susceptibility to	<input type="checkbox"/> No <input type="checkbox"/> Yes	sudden changes of heart beat	<input type="checkbox"/> No <input type="checkbox"/> Yes	joint pain	<input type="checkbox"/> No <input type="checkbox"/> Yes
infection	<input type="checkbox"/> No <input type="checkbox"/> Yes	high blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	muscle weakness	<input type="checkbox"/> No <input type="checkbox"/> Yes
immunosuppression	<input type="checkbox"/> No <input type="checkbox"/> Yes	swollen legs or feet	<input type="checkbox"/> No <input type="checkbox"/> Yes	muscle tenderness	<input type="checkbox"/> No <input type="checkbox"/> Yes
hay fever				joint swelling	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>Constitutional</b>	<input type="checkbox"/> No to All	<b>Respiratory</b>	<input type="checkbox"/> No to All	<b>Neurological/Psychiatric</b>	<input type="checkbox"/> No to All
fever, chills or shakes	<input type="checkbox"/> No <input type="checkbox"/> Yes	cough	<input type="checkbox"/> No <input type="checkbox"/> Yes	headaches	<input type="checkbox"/> No <input type="checkbox"/> Yes
night sweats	<input type="checkbox"/> No <input type="checkbox"/> Yes	shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	dizziness	<input type="checkbox"/> No <input type="checkbox"/> Yes
unintentional weight gain	<input type="checkbox"/> No <input type="checkbox"/> Yes	wheezing	<input type="checkbox"/> No <input type="checkbox"/> Yes	fainting	<input type="checkbox"/> No <input type="checkbox"/> Yes
unintentional weight loss	<input type="checkbox"/> No <input type="checkbox"/> Yes			anxiety	<input type="checkbox"/> No <input type="checkbox"/> Yes
				depression	<input type="checkbox"/> No <input type="checkbox"/> Yes
				agitation	<input type="checkbox"/> No <input type="checkbox"/> Yes

ALERTS	ALERTS	ALERTS
Allergy to:	Artificial Heart Valve	Pacemaker
Adhesive	Artificial joints within 2 years	MRSA/Staph
Lidocaine	Blood Thinners	Premedication Prior to Procedures
Topical Antibiotic Ointments	Defibrillator	Rapid Heartbeat with Epinephrine

**PREGNANCY AND CHILDBEARING INFORMATION FOR WOMEN ONLY**

Are you pregnant?  No  Yes      Planning on becoming pregnant soon?  No  Yes  
 Are you breastfeeding?  No  Yes      Are you on some form of birth control?  No  Yes If Yes, what form? \_\_\_\_\_