LAM DERMATOLOGY + ASSOCIATES

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

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

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

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: _____RELATIONSHIP:_____PHONE #:_____
ADDRESS:_____CITY:_____STATE:_____

SKIP IF INSURANCE CARD IS PROVIDED *****PLEASE PRESENT ID AND INSURANCE CARDS AT EVERY VISIT*****
PRIMARY INSURANCE:
INSURANCE CO._____POLICY #_____GRP #_____
NAME OF INSURED_____DOB_____RELATIONSHIP TO PATIENT_____
SECONDARY INSURANCE:
INSURANCE CO._____POLICY #_____GRP #_____
NAME OF INSURED_____DOB_____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*

_____ _____
Printed Name of Patient or Legal Representative (if applicable) *Date*

BENEFITS TO PHYSICIAN

I hereby authorize payments directly to Yaohan 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 have signed the patient Authorization for Use and Disclosure of Protected Health Information from Lam Dermatology.

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

LAM DERMATOLOGY + ASSOCIATES

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)*

LAM DERMATOLOGY + ASSOCIATES

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.

DISABILITY POLICIES AND FORMS

Disability policies are private policies owned by the patient. We charge **$15 per 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 is be prepaid at the time the form is left with our office. We require 5 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.

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.

_____ _____

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

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

_____ _____

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

LAM DERMATOLOGY + ASSOCIATES

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**

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

PAST MEDICAL HISTORY (other illnesses not listed above): _____

PAST SURGICAL HISTORY

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

□ OTHER: _____
_____
_____
_____

LAM DERMATOLOGY +ASSOCIATES

SKIN DISEASE HISTORY

□ Acne
□ Actinic Keratosis
□ Blistering Sunburns
□ Dry Skin
□ Eczema
□ Flaking or Itchy Scalp
□ Hay fever/Allergies
□ Poison Ivy
□ Precancerous Moles
□ Psoriasis

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-PRESCIPTION MEDICINES

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

□ Never Drink Alcohol
□ Never Smoked
□ less than 1 drink per day
□ Quit, Former Smoker
□ 1-2 drinks per day
□ Smokes Less Than Daily
□ 3+ drinks per day
□ Smokes Daily

Name _____ **Date** _____

REVIEW OF SYSTEMS AND ALERTS

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

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

ALERTS		ALERTS		ALERTS	
Allergy to:		Artificial Heart Valve	□ No □ Yes	Pacemaker	□ No □ Yes
Adhesive	□ No □ Yes	Artificial joints within 2 years	□ No □ Yes	MRSA/Staph	□ No □ Yes
Lidocaine	□ No □ Yes	Blood Thinners	□ No □ Yes	Premedication Prior to Procedures	□ No □ Yes
Topical Antibiotic Ointments	□ No □ Yes	Defibrillator	□ No □ Yes	Rapid Heartbeat with Epinephrine	□ No □ Yes

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? _____