LOS GATOS
DERMATOLOGY

777 Knowles Drive, Suite 16
Los Gatos, California 95032
(408) 374-1320 • Fax (408) 374-3480
www.LosGatosDermatology.com

PATIENT REGISTRATION FORM

Please fill out completely.
Please print clearly.

First Name _____ Last _____ Date _____

Age _____ **Date of Birth** _____ **Sex** _____ **Married** ____ **Single** ____ **Widowed** ___ **Divorced**___

Referred by _____ E-mail Address _____

Home Address _____ City _____ State _____ Zip code _____

Mailing Address _____

Phone No. ( ) _____ Cell No. ( ) _____ Occupation_____

Pharmacy Name _____ Street Address _____

Employed by _____ Phone No. ( ) _____

Address _____ City _____ State _____ Zip code _____

Spouse or Parent Name _____ Occupation _____

Employed by _____ Phone No. ( ) _____

Address _____ City _____ State _____ Zip code _____

Name of relative or close friend in case of Emergency _____ Phone No. ( ) _____

Employed by _____ Phone No. ( ) _____

Medical Insurance: ___ **NO** ___ **HMO** ___ **Yes, Insurace Company** _____

INSURANCE INFORMATION

Please present all insurance cards/documentation at each visit.

Primary Insurance: _____ Co-Payment: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Policyholder's Name: _____ **Date of Birth:** _____/_____/_____

Relationship to Insured:_____

Insurance ID Number: _____ Group #: _____

Effective Date: _____/_____/_____

Secondary Insurance: _____ Co-Payment: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Policyholder's Name: _____ Date of Birth: _____/_____/_____

Relationship to Insured:_____

Insurance ID Number: _____ Group #: _____

Effective Date: _____/_____/_____

Permission is given to Bruce M. Saal M.D. and staff to call me at work, home, cell phone and/or leave voice mail messages (per my instruction) to confirm appointments or communicate medical information.

Signature _____ Date _____

Bruce Saal, M.D.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Initials _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment

I understand if I no show for two consecutive appointments I will be charged $75.00, of which I must pay prior to scheduling of any future appointments.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Initials _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at Bruce Saal, M.D., I agree to pay the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Initials _____

Assignment of Benefits – Financial Agreement

I have read the above policy regarding my financial responsibility to Bruce Saal, M.D. for providing medical services to me or the patient listed below. I certify that the information is, to best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Bruce Saal, M.D., the full and entire amount of bill incurred by my or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient/Guarantor Initials _____

Joint Notice of Privacy Practices (NPP) Acknowledgment

A Joint Notice of Privacy Practice (NPP) is provided to all patients. This NPP identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access, amend medical information, request an accounting of disclosures, and request additional restrictions on our uses and disclosures of that information; 3) your right to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

By signing below, I hereby acknowledge I've read the "Notice of Privacy Practices."

Patient/Guarantor Signature_____ **Date** _____

Employee/Witness Signature_____ ***Date*** _____

Patient Name:_____ **DOB:**_____

MEDICAL HISTORY

Name _____ Birth Date _____ Date _____

ALL INFORMATION IS ABSOLUTELY CONFIDENTIAL

Please list the reason(s) for today's visit:

_____

_____

ALLERGIES TO ALL INTERNAL OR EXTERNAL DRUGS OR CHEMICALS: _____

_____

CURRENT/PRESENT PRESCRIPTIONS & MEDICATIONS, ORAL & TOPICAL: _____

_____

DO YOU HAVE A HISTORY OF OR HAVE YOU EVER HAD:

YES	NO		YES	NO		YES	NO	
☐	☐	Asthma	☐	☐	Arthritis	☐	☐	Bleeding Problems
☐	☐	Breathing Problems	☐	☐	Joint Replacement	☐	☐	Heart Disease
☐	☐	Diabetes	☐	☐	Muscle/Bone Disease	☐	☐	Heart Murmur
☐	☐	Fainting/Dizziness	☐	☐	Artificial Heart Valve	☐	☐	High Blood Pressure
☐	☐	Food Allergy	☐	☐	Contact Lenses	☐	☐	Anemia
☐	☐	Glaucoma	☐	☐	Hearing Aids			
☐	☐	Liver Disease	☐	☐	Implanted Defibrillator	☐	☐	Abnormal Moles
☐	☐	Have You Ever Used IV Drugs?	☐	☐	Pacemaker	☐	☐	Eczema
☐	☐	Hepatitis/Jaundice	☐	☐	Kidney Disease	☐	☐	Sensitive Skin
☐	☐	History of Blood Transfusions	☐	☐	Migraine Headaches	☐	☐	Hay Fever
☐	☐	HIV Disease	☐	☐	Nerve Disease - Neurological	☐	☐	Herpes/Cold Sores
☐	☐	Stomach/Intestinal Problems	☐	☐	Emotional Problems	☐	☐	Shingles
			☐	☐	Seizures	☐	☐	Hives
			☐	☐	Hormone Problems	☐	☐	Pigment Problems of Skin
☐	☐	Difficulty Swallowing Pills	☐	☐	Thyroid Disease	☐	☐	Skin Cancer
☐	☐	Do You Drink Alcohol?	☐	☐	Tuberculosis	☐	☐	Tattoos
☐	☐	Do You Smoke?				☐	☐	Thickened Scars/Keloids
☐	☐	Cancer of any kind				☐	☐	Wound Healing Problems

FAMILY HISTORY

Eczema.....	YES ☐	NO ☐	Skin Cancer, Non-melanoma.....	YES ☐	NO ☐
Malignant Melanoma.....	YES ☐	NO ☐	Psoriasis.....	YES ☐	NO ☐

OTHER MEDICAL PROBLEMS (not listed above): _____

PREVIOUS SURGERIES: _____

PREVIOUS HOSPITALIZATIONS: _____

DO YOU NEED TO TAKE ANTIBIOTICS BEFORE HAVING MEDICAL OR DENTAL PROCEDURES? ☐ Yes ☐ No

HAVE YOU EVER TAKEN ORAL ANTIBIOTICS OR CORTISONE PILLS FOR MORE THAN 3 MONTHS CONTINUOUSLY? ☐ Yes ☐ No

HEIGHT: _____ **WEIGHT:** _____ (for Drug Dosing)

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

FOR WOMEN ONLY, AGES 15-55 (To determine possible use of all prescription, oral and topical drugs):

Do you have problems with vaginal yeast infections when taking oral antibiotics? ☐ Yes ☐ No

Are you sexually active at the present time? ☐ Yes ☐ No

Are you now, or do you plan to become pregnant in the coming year? ☐ Yes ☐ No

Are you breast feeding **now**? ☐ Yes ☐ No

Do you use **ANY** form of birth control? ☐ Yes ☐ No

☐ IUD ☐ Condoms ☐ Tubal ☐ Vasectomy ☐ Rhythm method ☐ Birth control pills

☐ Other, please explain: _____

If you are taking birth control pills, since when? _____ Any changes in BC pills in the last year? ☐ Yes ☐ No

About when was your last menstrual period? _____ Menstrual periods regular? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

Children's ages? _____

NOTE: THIS SECTION <u>MUST</u> BE UPDATED YEARLY.

Any additional comments?

BRUCE M. SAAL M.D. A MEDICAL CORP.

Patient Consent for Use and Disclosure of Protected Health Information

WITH MY CONSENT, DR. BRUCE SAAL MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION, (PHI) ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (TPO). PLEASE REFER TO DR. SAAL'S NOTICE OF PRIVACY PRACTICES FOR A MORE COMPLETE DESCRIPTION OF SUCH USES AND DISCLOSURES.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Saal reserves the right to revise the Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Saal's office.

With my consent, Dr. Saal and his staff, may call my home (or other designated location) and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my consent, Dr. Saal and his staff may mail to my home (or other designated location) any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Dr. Saal and his staff may e-mail to my home (or other designated location) any items that assist the practice in carry out TPO, such appointment reminder cards and patient statements. I have the right to request that Dr. Saal and his staff, restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

In addition, I understand that physicians in the state of California are licensed and regulated by the Medical Board of California who may be reached at (800) 633-2322 or www.mbc.ca.gov.

BY SIGNING THIS FORM, I AM CONSENTING TO DR. SAAL'S USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION TO CARRY OUT MY TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS:

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Saal may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

LOS GATOS
DERMATOLOGY

HIPAA Right of Access Form

for Family Member/Friend/Other Designated Person or Entity

I, _____, direct my health care and medical services provider(s) to disclose and release my protected health information described below to:

Name(s):	**Contact Information and Relationship:**
_____	_____
_____	_____

Health Information to be disclosed upon the request of the person named above–

(Circle either A or B):

A. **Disclose** my complete health record (including, but not limited to, diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR,

B. **Disclose** my health record, as above, BUT do NOT disclose the following (check as appropriate):

- o Communicable diseases (including HIV and AIDS)
- o Other (please specify): _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- o An electronic record or access through an online portal
- o Hard copy

This authorization shall be effective inclusive of (circle one)

- o All past, present, and future periods, OR
- o Date or event, (e.g. marriage, divorce, etc.)
  _____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care provider.

_____ _____

Printed Name of the Individual Giving this Authorization — Date of birth

_____ _____

Signature of the Individual Giving this Authorization — Date

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CONSENT FOR THE USE OF LASERS, AND INTENSE PULSED LIGHT

I authorize Bruce M. Saal, M.D. and/or his staff members to perform laser and /or intense pulsed light treatments upon me. Theses devices maybe used for the purpose of (but not limited to) ultra violet light (Blu-U), hair removal, tattoo removal, the treatment of pigmentation, the removal of moles or growths, blood vessels, birthmarks, scars, sun damage, age related changes, cellulite, stretch marks, collagen and tissue coagulation/heating. I understand that this procedure is by choice, multiple treatments may be necessary to achieve optimal results and that results, as in any medical procedure, vary with each individual.

I understand that:

Common side effects may include redness, swelling, skin sensitivity, scaling of the skin, crusting, etc. Most all of these effects are temporary. Only rarely may they last longer than a few days/weeks.

Pigmentation changes (darkening or lightening of the treated skin) is often a desired effect of the treatment, but may sometimes be noticeable and last for a prolonged period of time. Very rarely, an exaggerated change in skin pigmentation may be permanent.

Other less common effects such as severe crusting, infection, significant pain, or bruising may occur. Scaring or texture change of the skin may occur VERY RARELY.

It is advisable to protect your skin from the sun (and tanning lamps) both before and after the treatment(s). Ultraviolet exposure may cause undesirable pigmentation or improper healing to occur.

Proper skin care both before and after the procedure is important and instructions should befollowed carefully.

Keep your eyes closed while having these treatments or wear protective eye wear, as laser and light sources create intense beams of light that can possibly injure the eye.

Pretreatment photos are taken of all patients to better evaluate the effectiveness of the treatment. Rarely, these photos may be used for further medical education, professional publications and very rarely, for commercial purposes. In general, if the area of treatment (a birthmark, a mole , a section of skin, etc.) will not reveal my identity then these photos may be used as noted above to illustrate the benefit of a treatment. NO PHOTOS REVEALING MY IDENTITY MAY BE USED WITHOUT MY EXPRESS WRITTEN CONSENT.

The purpose of this procedure, and any questions I have, has been fully explained to me to my satisfaction. I will try my very best to cooperate with the treatment and any necessary follow up care. I have read and understood the above, and consent to having this treatment. No guarantee or assurances of outcome have been made or implied to me regarding this/these treatment(s) by Dr. Saal or any members of his staff

Patient Signature _____ Date _____

Print Name _____

Witness _____ Date _____

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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Los Gatos Dermatology. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan. If your insurance company does not consider the charges medically necessary, the patient is responsible for payment.
- Co-pays are due at the time of service.
- Co-insurance, deductibles and non-covered items are due 30 days from receipt of billing.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
- Charge for returned checks
- Charge for missed appointments without 24 hours' notice

By my signature below, I hereby authorize assignment of financial benefits directly to Los Gatos Dermatology. I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

_____

Patient's Name

_____ _____

Signature of patient or guardian Date

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