PATIENT REGISTRATION

FORM A-9

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor	Email Address			
Patient's Social Security Number		California Driver's License No.		
Home Address	City	State	Zip	
Mailing Address if Different	City	State	Zip	
Home Telephone Number		Work Telephone Number		
Occupation		Employer's Name		
Employer's Address	City	State	Zip	
Spouse Name		Employer		
Other Physician's Name				
Whom May We Thank for Referring You to Our Practice?				
NOTIFY IN CASE OF EMERGENCY				
Name		Relationship		
Address	City	State	Zip	
Home Telephone		Work Telephone		
Nearest Relative (not living with your)				
Home Telephone		Work Telephone		
FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES				
Name		Telephone		
Address	City	State	Zip	
Insurance Company		Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#.		
Insurance ID No.:				
Secondary Insurance		Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN#		
Were You Injured on the Job? YES NO		Have you Informed Your Employer? YES NO		
Date of Original Injury:				
Worker's Compensation Carrier Name		Address		

Please Read Our Financial Policy Statement and Agreement on Reverse

MEDICAL PROBLEMS SUMMARY SHEET

Patient Name:_____ Primary Care Physician:_____

Preferred Pharmacy/Location:_____

Have you had any of the following:	**Medical Problems:**
Basal Cell Carcinoma Yes No	
Squamous Cell Carcinoma Yes No	
Pre-cancers frozen off Yes No	
Melanoma Yes No	
Atypical Moles Yes No	
Oral Herpes Yes No	
Genital Herpes Yes No	
Eczema Yes No	**Past Surgeries/Injuries:**
Hepatitis (A, B or C) Yes No	
HIV/AIDS Yes No	
Current Pacemaker/Defibrillator Yes No	
Blood disorders/ Enzyme deficiencies/ liver disorders/ Heart disease/seizures Yes No	

Current Medications:	**Drug Allergies**
	[ ] No known drug allergies
	[ ] Yes (please specify):
	Family History
	Melanoma Yes No
	Social History
	Tobacco Use: Yes No
	Alcohol Use: Yes No
	Sun Exposure:
	Minimal Moderate Extensive

COSMETIC INTEREST QUESTIONNAIRE

Name: _____ Date: _____

At Aloe 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 (You may stop here)

Health issues and procedures or products of interest to you (please check all that apply).

☐ **Laser Treatments** to address:
- ☐ Vessels and redness
- ☐ Brown spots
- ☐ Wrinkles, lines, poor skin texture
- ☐ Scars

☐ **Chemical Peels** for acne, sun spots, fine lines, and poor skin texture

☐ **BOTOX Cosmetic** for unwanted wrinkles
- ☐ Between eyebrows
- ☐ Around eyes
- ☐ Forehead

☐ **Facial fillers** (Juvederm Ultra, Juvederm Voluma, Vollure, Vobella etc.)
- ☐ Improve unwanted lines and facial folds
- ☐ Correct age related volume loss of the cheeks and restore facial contours

☐ **Sclerotherapy** for unwanted veins

☐ **Skin Care Products** for sun protection and rejuvenation

☐ **Latisse** for longer, darker, fuller eyelashes

Other (please specify): _____

_____

Aloe Dermatology
Financial Policy

We collect full payment for services rendered and any products purchased at the time of your visit.

We accept **some** insurances offered by: Anthem Blue Cross PPO, Blue Shield PPO, Aetna PPO and Medicare.

Note: We are NOT contracted providers for ANY HMO PLANS. This includes any Medicare HMO plans. We do not courtesy bill for any HMO insurance. Additionally, we do not accept patients who have Medi-Cal insurance as their primary OR secondary insurance as we are not Medi-Cal providers. This means we are not providers for patients who have Medicare as their primary insurance and Medi-Cal as their secondary insurance.

Note: We are NOT contracted providers for any Affordable Care Act Insurance Plans (also known as Obamacare, Covered California, or Exchange Plans) including those offered by Blue Cross, Blue Shield and Aetna.

We advise you call the telephone number on the back of your insurance card or go online to confirm that we are a contracted provider with your specific plan. We may be listed with your insurance as Aloe Dermatology, George Keith Llewellyn MD Inc, George Keith Llewellyn MD, George Llewellyn MD or Keith Llewellyn MD. It is the patient's responsibility, not the practice's responsibility, to determine whether or not we are a contracted provider for your specific plan.

If we accept your insurance, then you will be required to pay the co-pay indicated by your plan at the time of service. We will then bill your insurance for the services rendered. You will be required to pay your deductible, co-pays and any co-insurance not covered by your insurance, if applicable. In the event your insurance company categorizes services rendered as "pre-existing," "non-covered," or "not medically necessary," you are responsible for payment in full.

Private pay
If we do not accept your insurance, full payment will be expected at the time of service. You will be provided with a billing statement at the conclusion of your visit. If you have insurance that we do not accept, we will, as a courtesy, bill your insurance for you (except for HMO insurance). Depending on your particular insurance, some or all of the charges from your visit may be reimbursed to you by your insurance company.

Cosmetic Services
Regardless of whether or not we are providers for your particular insurance, full payment for cosmetic services and products is expected at the time of service. Cosmetic procedures are not covered by insurance.

Returned Check Fee
A charge of $25 will be due from the patient for any returned check.

I authorize the release of any medical information necessary to process my insurance claim(s).
I understand that I am responsible for payment for all services rendered by Aloe Dermatology.

I have read, understood and agree with the financial policy of Aloe Dermatology.

Signature:_____ **Date:**_____

Print Name: _____

Assignment of Payment (Sign only if we accept your insurance)
For those insurance companies in which Dr. Llewellyn and his associates are participating providers, I assign all medical and surgical benefits to be made to Aloe Dermatology. I understand that I am financially responsible for all charges whether or not paid by my insurance.

Signature:_____ **Date:**_____

CONSENT TO TREAT
I give consent to Dr. George Keith Llewellyn and his certified physician assistants/RN(s) to examine and treat my medical/cosmetic conditions.

Signature:_____ **Date:**_____

NOTICE OF PRIVACY PRACTICES

George Keith Llewellyn MD, Inc. (Aloe Dermatology)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 9th, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Dr. Keith Llewellyn for more information, in person or in writing.

Aloe Dermatology

George Keith Llewellyn MD, Inc.

Your signature below acknowledges that you have had the opportunity to review our Notice of Privacy Practices. This document is available in our new patient registration packet, and is posted on our website, www.aloedermatology.com, as well as in our office. You also may request a copy of our Notice of Privacy Practices from our staff.

Print Name: _____ Signature: _____

Date: _____

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my health care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

Patient Signature: _____ Date: _____

Please list below the names of persons with whom we may speak with in regard to your personal health information. You do not need to list any other Physicians. You may leave this area blank if there is no one with whom we may speak.

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Open Payments Database Notice

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here: https://openpaymentsdata.cms.gov. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

Please sign and date below to indicate you have received this notice.

Patient Signature _____

Date _____

Appointment Cancellation & No Show Policy

In order to give you our full and undivided attention, we have reserved time for your appointment.

We need at least a 24 hour notice of cancellation so that another patient in need can be seen in the event you are unable to make your appointment.

Failure to provide a notice of cancellation at least 24 hours in advance of your appointment will result in a $75.00 charge per incident. No Shows (visits where a patient is scheduled for an appointment and does not show up and does not notify us in advance) will be charged a $75.00 fee per incident.

For Mohs Surgery appointments, no shows and failure to provide a notice of cancellation at least 24 hours in advance of your Mohs Surgery appointment will result in a $150.00 charge per incident.

I acknowledge I have read and understand the above policy.

_____

Name (please print)

_____

Signature

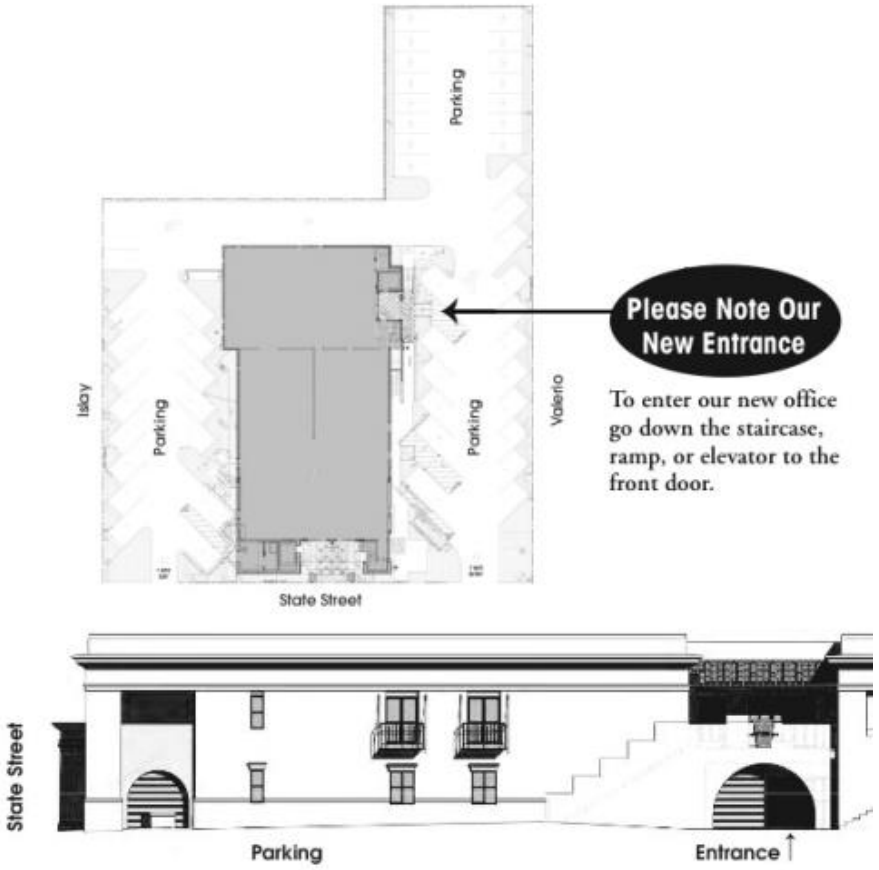
_____

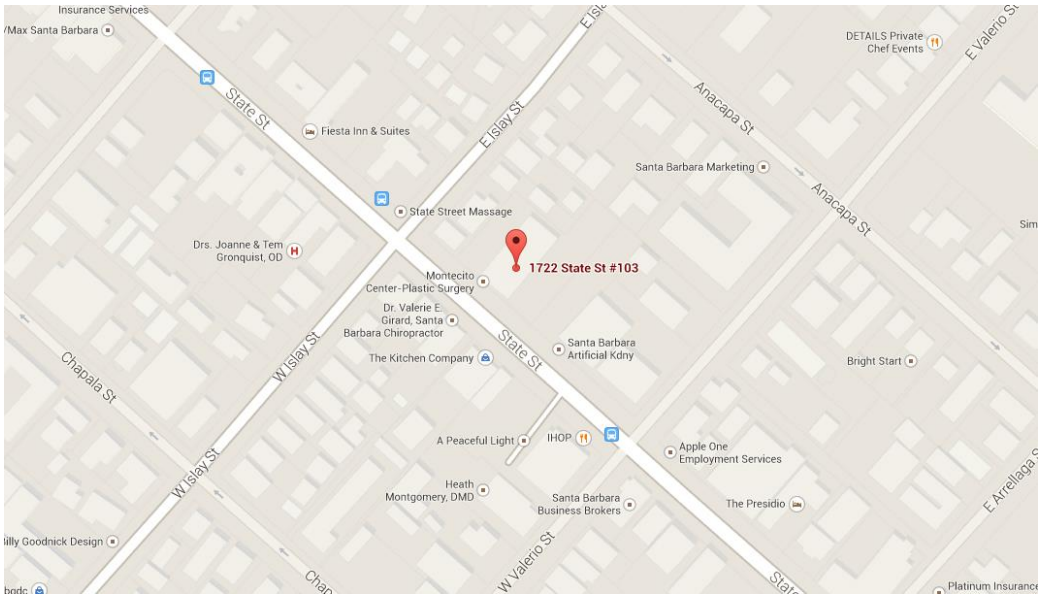
Date

Directions to Aloe Dermatology (Santa Barbara Office)

From the North: Take the 101 south and exit Mission. Left on Mission to State Street. Right on State and turn left into the one-way driveway. Parking is on the right side of the building at 1722 State.

From the South: Take 101 north and exit Arrellaga Street. Right on Arrellaga to State Street. Left on State Street and turn right into the one-way driveway. Parking is on the right side of the building at 1722 State.





Directions to Aloe Dermatology (Santa Ynez Office)

Directions from the west: Take the 246 east, take a left on Edison Street. Take the 3rd right onto Sagunto Street. 3615 Sagunto is on the left hand side of the street.

Directions from the north: Take the 154 south. Go west (take a right) onto the 246. Right onto Edison Street. Take a right on the 3rd Street (Sagunto). 3615 Sagunto is on the left hand side of the street.