Heller Dermatology and Aesthetic Surgery

Alan Heller, M.D., Misha Heller, M.D., and Justin Heller, M.D.

PROFESSIONAL OFFICE BUILDING
1760 TERMINO AVENUE, SUITE #114
LONG BEACH, CALIFORNIA 90804
PHONE (562) 498-2459, FAX (562) 494-8285

Patient Registration
(PLEASE PRINT)

Today's Date: _____

Patient: _____ Birthdate: _____/_____/_____ Age:_____
(FIRST) (MIDDLE) (LAST)

Home Address:_____ Home Phone: (_____)_____
(STREET) (APT. #)

Cell Phone: (_____)_____

_____ Work Phone: (_____)_____
(CITY) (STATE) (ZIP CODE)

Soc. Sec. #:_____ Email: _____

Sex: ____ Driver's Lic. #: _____ Marital Status: _____ Spouse's Name:_____

Employer Name: _____

Employer Address: _____

Employer Phone:(_____)_____ Occupation: _____

Referred By: _____

Responsible Party Information
(IF MINOR)

Name: _____ Relationship: _____
(FIRST) (MIDDLE) (LAST)

Home Address:_____ Home Phone: (_____)_____
(STREET) (APT. #)

Cell Phone: (_____)_____

_____ Work Phone: (_____)_____
(CITY) (STATE) (ZIP CODE)

Soc. Sec. # _____ Email: _____

Employer Name: _____

Employer Address: _____

Employer Phone:(_____)_____ Occupation: _____

May we leave a message on your home answering machine? . . . . . ☐ Yes ☐ No

May we leave a message for you at work to call us? . . . . . ☐ Yes ☐ No

May we discuss your medical condition with another person? . . . . . ☐ Yes ☐ No

If yes, with whom _____ Relationship: _____

In Case of Emergency, You May Contact:

Name: _____ Relationship:_____

Address: _____ Phone: (___)_____

All charges are the direct responsibility of the patient. Payment is due at the time services are rendered. I hereby authorize the release of my medical information, if necessary, to process a claim or for further treatment or care by physicians.

Patient's Signature _____ **Date:**_____
(PARENT/GUARDIAN IF PATIENT IS A MINOR)

For Contracted Insurance Patients: I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company.

Patient's Signature _____ **Date:**_____
(PARENT/GUARDIAN IF PATIENT IS A MINOR)

BRING YOUR INSURANCE CARD WITH YOU TO YOUR APPOINTMENT.

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Medical Information
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I. Medical History
Do you have or have you ever had:

Heart Attack / Angina	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Artificial Heart Valve / Joint	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Dizziness / Fainting Tendency	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Frequent or Severe Headaches	☐ Yes	☐ No
Epilepsy (Seizures) / Strokes	☐ Yes	☐ No
Bleeding Problems	☐ Yes	☐ No
Anemia or Blood Disorder	☐ Yes	☐ No
Abnormal Response to Cold	☐ Yes	☐ No
Poor Wound Healing	☐ Yes	☐ No
Skin Pigment Problems	☐ Yes	☐ No
Keloids or Abnormal Scars	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Condition	☐ Yes	☐ No
Kidney or Bladder Problems	☐ Yes	☐ No
Hepatitis / Liver Disease	☐ Yes	☐ No
AIDS / HIV Positivity	☐ Yes	☐ No
Fever Blisters / Cold Sores	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Sinus or Hay Fever	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Depression / Mental Illness	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
If yes, what type(s)? _____		
Radiation Treatment	☐ Yes	☐ No
If yes, which site? _____		
Are you Under Medical Treatment Now?	☐ Yes	☐ No
Are you Pregnant?	☐ Yes	☐ No
Are you Breastfeeding?	☐ Yes	☐ No

Please specify all medical illnesses:

_____
_____
_____
_____
_____
_____

II. Skin Cancer History
Do you have a personal history of skin cancer:

Melanoma	☐ Yes	☐ No
Basal Cell Carcinoma	☐ Yes	☐ No
Squamous Cell Carcinoma	☐ Yes	☐ No
Any other Skin Cancers	☐ Yes	☐ No

If yes, please specify type of skin cancer, site, and year treated:

_____
_____
_____

II. Allergies
Are you allergic or sensitive to:

Penicillin	☐ Yes	☐ No
Sulfa Antibiotics	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
General Anesthesia	☐ Yes	☐ No
Any other medications or foods	☐ Yes	☐ No

If yes, which medications or foods? And, what happens?

_____
_____

III. Medications
Are you taking:

Aspirin	☐ Yes	☐ No
Cortisone / Prednisone / Steroids	☐ Yes	☐ No
Anticoagulants / Blood Thinners	☐ Yes	☐ No
Tranquilizers / Sedatives	☐ Yes	☐ No
Insulin	☐ Yes	☐ No
Vitamins or Herbal Supplements	☐ Yes	☐ No
Any other medications or drugs	☐ Yes	☐ No

Please list all current medications (prescription medications, over-the-counter medications, vitamins, and herbal supplements):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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IV. Family History

Do you have family history of:

Melanoma . . . . . ☐ Yes ☐ No
Dysplastic Nevi (Atypical Moles) . . . . . ☐ Yes ☐ No
Other Skin Disorders . . . . . ☐ Yes ☐ No
If yes, please specify _____

_____

IV. Surgical History

Please list all prior surgeries (Type & Year of Surgery):

_____

_____

_____

_____

_____

V. Social History

What is your approximate daily consumption or use of:

Alcohol: _____

Tobacco: _____

Caffeine (Coffee / Tea / Soda): _____

VI. History of Previous Skin Exams

Have you ever seen a Dermatologist? . . . . . ☐ Yes ☐ No

Doctor's Name:_____

Date Last Seen:_____

(If you would like us to request your records, please request and sign a medical release form from your previous doctor's office.)

VII. Preferred Pharmacy

Pharmacy Name:_____

Pharmacy Address:_____

_____

Pharmacy Phone #: (_____)_____

Patient Signature: _____ **Date:** _____

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FINANCIAL POLICY

Thank you for choosing **DR. ALAN HELLER, DR. JUSTIN HELLER, and DR. MISHA HELLER** as your health care providers. We are committed to the success of your treatment. Please understand that prompt payment of the services provided allows us to continue giving you the best possible care. The following is a statement of our financial policy which we require that you read, agree to, and sign prior to any service. This financial policy applies to all services rendered by our group. It is our policy that the PATIENT (or the parents or guardians of a minor) is responsible for full payment of all services rendered.

For patients WITHOUT insurance coverage, full payment is due upon receipt of any office services.

For patients WITH insurance coverage:

The insurance policy is a contract between the patient and his/her insurance company. It is the patient's responsibility to know your insurance plan and to verify eligibility and benefits. Office copayments (if applicable) are due in full at time of service. All information required for claim submission must be provided by the patient; otherwise, that insurance company may not be billed. Any balance not paid by insurance will be due in full on next office appointment or upon receipt of our statement.

Insurance Information:

Name of Insurance Company:_____

Policy Number: _____ Group Number: _____

Subscriber: _____ Relationship: _____

Do you have a Secondary Insurance?_____ Name of Insurance Company: _____

Policy Number:_____ Group Number: _____

Subscriber:_____ Relationship: _____

For services outside of our office, there will be a separate charge from the facility where services are rendered. Any tests ordered by our doctors (i.e.: laboratory, radiology, etc.) will also be a separate charge from the corresponding providers.

We accept cash, check, Visa, MasterCard and Discover payments. If requested, a short payment schedule may be considered for patients with special financial conditions.

Again, thank you for entrusting us with your care. If you have any questions regarding your financial responsibilities or payment options, please call our office.

Signature: _____ **Date:** _____
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WAIVER FOR "NOT MEDICALLY NECESSARY" AND/OR COSMETIC PROCEDURES

Physician Notice

Your Insurance Carrier will pay only for dermatologic services that are designed to treat an illness or injury. Your carrier does not cover some or all of the services we render because they are deemed "not medically necessary" and/or cosmetic in nature.

Beneficiary Agreement

I have been notified by my physician that my insurance carrier will not cover some or all of the services rendered for the reason stated above. Since I have been notified in advance of this determination, I agree to be personally and fully responsible for payment for services rendered by my physician.

I understand that my doctor will not file a claim for any services considered to be "not medically necessary," and/or cosmetic.

I understand and agree that the charges for any "not medically necessary" and a/or cosmetic services must be paid in full by me.

Beneficiary Signature: _____ **Date:** _____
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NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. **To provide treatment:** We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, technician, nurse, and business office staff, in pathology laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to authorize health care providers treating patients even when the provider requesting the results did not originally order the tests.
2. **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.
3. **To conduct health care operations:** Your health information may be used during performance evaluations of our staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.
4. **Communications:** Because we believe regular follow-up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact us to make an appointment. These communications may include postcards, letters, emails, and telephone reminders. We may share your health information with those you tell us will be helping you with your home treatment, medications or payment. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.
5. **Required by law:** We may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court of administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Worker's Compensation and similar programs.

Our patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultation and correspondence are reviewed by the physician prior to being filed in the medical records. A written released signed and dated by the patient/guardian must be obtained prior to the release of medical record information.

You are entitled to receive a copy of this Notice of Privacy Practices.

I, _____, have had a full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, and health care operations and laboratory testing.

Signature: _____ **Date:** _____

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PHOTO CONSENT

I,_____, give permission for Heller Dermatology and Aesthetic Surgery and staff to use the photographs and videos taken for the practice's website, social media, and office use. I also understand there will be no financial compensation given for the use of my photos.

Please know that your name will remain confidential in all publications.

Print Name: _____

Signature:_____ **Date:** _____

□ I do not consent to photographs

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PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** 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 rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service 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. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, no supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2 Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statue of limitations, or (2) the claimants fail to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below: Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

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 provisions. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

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.

By:_____ _____
Patient or Patient's Representative's Signature (Date)

By:_____ _____ By: _____
Physician's or Authorized Representative's (Date) Print Patient's Name

_____ _____
Print or Stamp Name of Physician, Medical Group or Association Name (If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.