BELLA SKIN INSTITUTE

PATIENT INFORMATION FORM

23622 Calabasas Road, Suite 339
Calabasas, CA 91302
818-225-0117

ALLERGIES________________________

Patient: ____ SS#__________________________

Last name First Name MI

Date of Birth: ____________ Age: ____ Gender (circle) MALE FEMALE

Address: ____ Work: (_____)____________________
Mobile:(_____)____________________
____ Home: (_____)____________________

City State Zip

Referred by: __________________________

Has any family member been treated by us before? _ NO _ YES Who?: ___________________

Insurance Information: Do you have health insurance? __ YES __NO

Primary Insurance Company: ____

Policyholder's Name: ____Date of Birth: _________________

Policyholder's Social Security #: __________________ Relationship to Patient: ____________________

Secondary Insurance Company: ____ ________

Policyholder's Name: ____Date of Birth: _________________

Policyholder's Social Security #: __________________ Relationship to Patient: ____________ ________

May we leave personal medical information on your home answering machine? __YES__NO

May we e-mail you personal medical information? __ NO __ YES E-mail: ____________________________

May we discuss your medical information with family members? __YES __NO

If yes, please provide their names and phone numbers below.

Name: ____ Relationship: _________________ _

Day Phone: (___)_______________Cell Phone: (___)_________________Home Phone: (_ _) _________ _

Please present your insurance card(s) and your photo identification to the receptionist for photocopying. You will be asked for an updated Patient Registration Form once a year.

Signature (patient or parent/legal guardian): _______________________________ Date: __________

Payment is expected at the time of service for any part of the charges that are your responsibility. "Your part" varies depending upon your insurance plan. Please read the information below as it applies to your insurance coverage:

Private Pay: Payment for all services provided is due and payable at the time of service. If paying by check, there will be a $25.00 charge for all checks returned for insufficient funds.

HMO/PPO's: (Such as Aetna Us Healthcare, Cigna Healthcare, etc.) You are expected to pay the co-payment as defined by your plan upon arrival at the office. You are also responsible for payment of any deductible amounts and non-covered services upon exit. You will be billed for any amount due after insurance has paid. Prompt payment is then expected. Also, there may be a separate charge to an outside laboratory that you will be responsible for as well.

Cancellation Policy: You agree to accept responsibility for the office visit charge if you cancel and fail to give 24 hours notice prior to your appointment.

Medicare: You are responsible for 20% of Medicare's approved amount unless you provide our office with secondary insurance coverage at the time of your service.

MEDIGAP/CROSSOVER Plans: If you are covered by Medicare and you have a Medigap policy or are covered by a plan to which Medicare automatically crosses over the claim, you are responsible only for any unpaid deductibles you may have not yet paid.

WE ACCEPT MOST MAJOR CREDIT CARDS FOR YOUR CONVENIENCE

I have read, and I understand my financial obligation to The Center for Dermatology Care, and I agree to abide by the terms stated above.

Signature of Patient or Legal Guardian: ____ **Date:** ________________

Relationship: _________________________

AUTHORIZATIONS/ACKNOWLEDGEMENTS

MEDICARE

I hereby authorize any provider of services to me who files a claim to the Medicare Program, its intermediaries or carrier and to Medigap and any plan to which Medicare crossover to release medical or other information about me that is required for the adjudication of a claim submitted for care provided to me. I also assign payment of any health benefits due me to the party who files an assigned claim to the Medicare program for services provided to me. This authorization is for my lifetime unless revoked in writing by me or my legal guardian or assign.

Signature of Patient or Legal Guardian: ____ **Date:** _______________

Relationship: ______________________________

PRIVACY NOTICE: I have reviewed a copy of the Privacy Rules from The Center for Dermatology Care.

Signature of Patient or Legal Guardian: ____ **Date:** _______________

Relationship: _______________________________