BELLA SKIN INSTITUTE

23622 Calabasas Rd #339 Calabasas CA 91302
818.225.0117

Patient Information Form

Allergies: _____

Patient: _____ **Last 4 of SSN#:** _____
Last First MI

Date of Birth: _____ **Age:** _____ **Gender (circle) MALE FEMALE**

Address: _____ **Home: (_____) _____-_____**
Cell: (_____) _____-_____
_____ **Work: (_____) _____-_____**

We now confirm appointments via e-mail. Please provide yours below:
_____

☐ Check box if you do not wish to receive E-mail Promotions/Specials/Communications from BSI

Referred by: _____

Has any family member been treated by us before? No ____ Yes ____ Who? _____

Insurance Information: 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 discuss your medical information with family members? Yes _____ No_____

If yes, please provide their name and phone numbers below:

Name: _____ **Relationship:** _____

Day Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____Work Phone: (_____) _____-_____

Please present your insurance card(s) and photo ID to the receptionist for photocopying. You will be asked for an updated patient information form once a year.

Signature (patient or parent/legal guardian): _____ **Date:** _____

NOTICE TO CONSUMERS:

Medical Doctors are licensed and regulated by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

Physician Assistants are licensed and regulated by the Physician Assistant Committee
(916) 561-8780
www.pac.ca.gov

I have read and understand the physician is licensed and regulated by the board.

Signature of Patient or Legal Guardian: _____ _____ Date: _____ ____ Relationship: _____

Bella Skin Institute Financial Policy

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 $50 charge for all checks returned for insufficient funds. Initial: _____

Copies of Medical Records are subject to a $25 fee. Initial: _____

HMO/PPO's: (Such as Aetna US Healthcare, Cigna Healthcare, etc.) You are expected to pay the co-payment 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. Initial: _____

Cancellation Policy: You agree to accept responsibility for the office visit charge of $25 if you fail to give 24 hours notice prior to your appointment. Initial: _____ If appointment is for surgery or a cosmetic procedure which requires a 30 minute block for Dr/PA-C schedule then a $75 fee will apply. Initial: _____

Medicare: You are responsible for 20% of Medicare's approved amount unless you provide our office with secondary insurance coverage at the time of 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 Bella Skin Institute, and I agree to abide by the terms stated above.
Signature of Patient or Legal Guardian: _____ Date: _____

Relationship: _____

PRIVACY NOTICE: I have reviewed a copy of the Privacy Rules from Bella Skin Institute.
Signature of Patient or Legal Guardian: _____ Date: _____

Relationship: _____

MEDICARE
I hereby authorize any provider of services to me who files a claim to Medicare Program, it's 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: _____