Financial Policy

- Please read and sign the financial policy.

Patient Information Form

- Please fill out the highlighted areas.
- If there has been a change of **address** or **insurance** please indicate it on the form and let staff know when you arrive for your appointment.
- Please be sure to bring your insurance card with you.
- Indicate your pharmacy and the pharmacy address
- Sign form

Personal Medical History Form

- Please fill out completely and sign.

Manhattan Beach Dermatology Financial Policy

Payment is expected on the day services are rendered. We accept cash, checks, Visa, MasterCard, American Express and Discover.

For those patients who are covered by insurance, we will be happy to bill on your behalf, whenever medically applicable. Any co-pays, co-insurance and/or deductibles as specified by your insurance policy will be collected on the day of service.

We verify your insurance benefits prior to your appointment. So, if you have any questions about your coverage, please ask before services are rendered. Verification of insurance is NOT a guarantee of coverage. Medical necessity is up to the determination of your insurance provider. You, the patient, may be responsible for services even if Manhattan Beach Dermatology/Scott Rackett, MD is contracted with your insurance policy.

We collect an **estimate** at the time of service. If we have over-collected, please notify us and a refund will be issued promptly. You may have an additional balance after your insurance processes our claim. Any outstanding balance that is your responsibility will be expected to be paid in full within 30 days of notification.

To avoid a $50 cancellation fee, please provide at least 24 hours' notice if you cannot keep your appointment.

Thank you,

Scott Rackett, MD and Staff

I understand that I will be expected to pay for all applicable fees the day of service.

I understand that I am responsible for any balances not covered by my insurance.

I will assume responsibility of notifying this office of any changes to my insurance coverage.

I authorize the release of any medical or other information necessary to process my claim.

I authorize payment of medical benefits to Manhattan Beach Dermatology/Scott C. Rackett MD for medical services.

I understand that I will be charged $50 for any appointments cancelled or missed without 24 hours' notice.

I have read and agree to this financial policy.

_____ _____

Signature of patient/parent or legal guardian of a minor Date

_____ _____

Print Name Relationship to Patient

Patient Information

Manhattan Beach DERMATOLOGY MEDICAL CORPORATION

All patients under the age of 18 must be accompanied by a parent or legal guardian. (please print)

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt: _____ City: _____ State_____ Zip_____

Date of Birth_____ Age_____ Male ☐ Female ☐ Driver's License/ID#:_____ State _____

Home Telephone: (_____) _____ Cell Phone (_____) _____ Social Security Number: _____

(Protected by HIPPA Privacy Act)

Single ☐ Married ☐ Widowed ☐ Divorced ☐ Race_____ Ethnicity_____ Preferred Language_____

Employer: _____ F/T ☐ P/T ☐ Unemployed ☐ Work Phone :(____) _____

Occupation: _____ Employer Address: _____

Email Address: _____ ☐Yes ☐NO May we communicate with you via e-mail

(We will never share your email address with anyone)

How were you referred to this office? ☐ Insurance ☐ Friend ☐ Doctor: _____ (doctor's name and city)

Primary Physician Name: _____ Phone_____ Fax_____

Preferred pharmacy address and phone number: _____

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

GUARANTOR/INSURED INFORMATION: If you are **NOT** the policyholder, please provide the following:

Policyholder's name: _____ Male ☐ Female ☐ Date of Birth _____

Policyholder's address: _____ Patient's relationship to policyholder: _____

Policyholder's Social Security number: _____ (Protected by HIPPA Privacy Act)

Employer: _____ Employer address: _____

EMERGENCY

Name: _____ Relationship to patient: _____

Home telephone: (_____) _____ Work telephone: (_____) _____

Do we have your permission to:

1. Leave messages on your answering machine regarding confidential biopsy/lab results?
   Yes ☐ No ☐ If yes, please note preferred phone number: ☐ Home ☐ Cell ☐ Work ☐ Other (___) _____

2. Discuss your medical condition with any member of your household? Yes ☐ No ☐
   If yes, whom: _____ Relationship: _____ ☐ Same as emergency contact

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received a copy of Manhattan Beach Dermatology's Notice of Privacy Practices.

Signature **X**_____ _____ _____ Date _____

Patient signature / Parent or legal guardian of minor | Print Name | Relationship to patient

ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Signature **X**_____ _____ _____ Date _____

Patient signature / Parent or legal guardian of minor | Print Name | Relationship to patient

Personal Medical History

Manhattan Beach DERMATOLOGY MEDICAL CORPORATION

Name_____ **Date**_____

REASON FOR TODAY'S VISIT_____

PAST MEDICAL HISTORY: (check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH (Enlarged Prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Acid Reflux Disease)
- ☐ Hearing Loss
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ High Cholesterol
- ☐ Over Active Thyroid
- ☐ Under Active Thyroid
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other_____

_____

PAST SURGICAL HISTORY

- ☐ Heart: Mechanical Valve
- ☐ Joint Replacement
- ☐ Other surgeries:

_____

_____

_____

Please let us know if you, are experiencing any of the following:

☐ Tuberculosis (or symptoms of TB; coughing & fever)

If yes, are you experiencing any of the following:

- Productive cough
- Night sweats
- Fatigue
- Malaise
- Fever
- unexplained weight loss

SKIN DISEASE HISTORY: (Check all that apply)

- ☐ Acne
- ☐ Actinic Keratosis (Precancers)
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
  Body Location_____
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
  Body Location_____
- ☐ Poison Ivy
- ☐ Precancerous Moles
  Body Location_____
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
  Body Location_____
- ☐ Other _____

_____

Do you wear sunscreen?

☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon?

☐ Yes ☐ No

Do you have a family history of Melanoma?

☐ Yes ☐ No

If yes, which relative?

_____

Manhattan Beach DERMATOLOGY MEDICAL CORPORATION

ALLERGIES: (Please enter all food, medical allergies and their reactions)

_____
_____
_____
_____
_____

MEDICATIONS: (Please enter all current medications)

_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY: (Check all that apply)

Drug and Alcohol use

☐ Drug use
☐ IV Drug use
☐ Alcohol-none
☐ Alcohol-less than 1 drink per day
☐ Alcohol-1-2 drinks per day
☐ Alcohol-3 or more drinks per day

Smoking Status

☐ Current every day smoker
☐ Current some day smoker
☐ Former smoker
☐ Never smoked

Occupation and Workplace

☐ Indoors ☐ Outdoors

FAMILY HISTORY: (Is there a history in your family of the following diseases?) Below the condition write down who in your family had the condition. (Mother, Father, Sister etc.)

☐ Acne	☐ Heart disease	☐ Malignant melanoma	☐ Other Cancer(s)_____
_____	_____	_____	_____
☐ Allergies / Hay Fever	☐ Lung disease	☐ Basal cell skin cancer	_____
_____	_____	_____	
☐ Asthma	☐ Psoriasis	☐ Squamous cell skin cancer	☐ Other condition(s)_____
_____	_____	_____	_____
☐ Eczema	☐ Abnormal Moles	☐ Actinic keratosis (precancers)	_____
_____	_____	_____	

Personal Medical History

Manhattan Beach DERMATOLOGY MEDICAL CORPORATION

REVIEW OF SYSTEMS: (CHECK ALL THAT CURRENTLY APPLY)	
☐ Immunosuppression	☐ Pacemaker
☐ Changing mole	☐ Defibrillator
☐ Rash	☐ Artificial joints within past two years
☐ Abdominal pain	☐ Artificial heart valve
☐ Anxiety	☐ Do you need medication prior to procedures
☐ Bloody Stool	☐ Allergy to adhesive
☐ Bloody Urine	☐ Allergy to topical antibiotic ointments
☐ Blurry Vision	☐ Blood thinners
☐ Chest Pain	☐ Allergy to lidocaine
☐ Cough	☐ Rapid heartbeat with epinephrine
☐ Depression	☐ Yeast infections with antibiotics
☐ Fever or Chills	☐ GI upset with antibiotics
☐ Headaches	☐ Problems with bleeding
☐ Hay Fever	☐ Problems with healing
☐ Light headedness, dizziness	☐ Problems with scarring (hypertrophic or keloid)
☐ Joint Aches	☐ Allergy to latex
☐ Muscle Weakness	☐ Nursing currently
☐ Neck Stiffness	☐ Pregnant currently or Planning a pregnancy
☐ Night Sweats	☐ Lightheaded / pass out during procedures
☐ Shortness of Breath	
☐ Sore Throat	Birth Control Method:
☐ Thyroid Problems	Number of Children:
☐ Unintentional Weight Loss	Children Ages:
☐ Wheezing	

Patient signature / Parent or legal guardian of minor	Print Name	Relationship to patient	Date