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)

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

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_____ **Reason for today's Visit**_____

Medication Allergies:_____

Type of reaction_____

NON-MEDICATION ALLERGIES: Latex____ Others (food, tape, etc)_____

CURRENT MEDICATIONS:_____

_____ **DO YOU REGULARLY TAKE ASPIRIN?** □ Yes □ No

MEDICAL HISTORY: (check all that apply)

□ Anemia	□ Cataracts	□ Herpes simplex (cold sores)	□ Thyroid disease
□ Arthritis	□ Cholesterol	□ High Blood Pressure	□ Tuberculosis (or symptoms of TB; coughing & fever)
□ Artificial Joint	□ Colon/intestinal disorder	□ HIV disease (AIDS)	If yes, are you experiencing any of the following:
□ Artificial heart valve	□ Depression	□ Hives	o Productive cough
□ Asthma	□ Diabetes	□ Kidney Disease / Stones	o Night sweats
□ Abnormal moles	□ Eczema	□ Lung disease	o Fatigue
□ Bleeding, excessive	□ Epilepsy / Seizures	□ Malignant melanoma	o Malaise
□ Cancer	□ Glaucoma	□ Mitral Valve Prolapse	o Fever
type_____	□ Hair loss	□ Neurological problems	o unexplained weight loss
□ Skin cancer	□ Liver disease	□ Pacemaker	□ Ulcers
□ Basal Cell Carcinoma	□ Hay Fever / Allergies	□ Psoriasis	□ Warts
Site_____	□ Heart problems / Murmur	□ Scarring / Keloids	□ Genital Warts
□ Squamous cell carcinoma	□ Hepatitis (A,B, or C)		
Site_____			

Other Condition(s) describe_____

WOMEN ONLY: Birth control method_____ □ Currently pregnant _____wks

□ Actively trying to conceive Number of Children and ages _____

HOSPITALIZATION/SURGICAL HISTORY: (past 2 years)_____

_____

SOCIAL HISTORY: Do you smoke/chew tobacco? □ Never □ Every day □ Sometimes □ Former smoker

Do you drink alcohol? □ Yes ___drinks per day □ NO

FAMILY HISTORY: Is there a history in your family of the following diseases?

□ Acne	□ Eczema	□ Malignant Melanoma	□ Tuberculosis
□ Allergies / hay fever	□ Heart disease	□ Psoriasis	□ Other condition(s) _____
□ Asthma	□ Lung disease	□ Skin cancer Types _____	_____

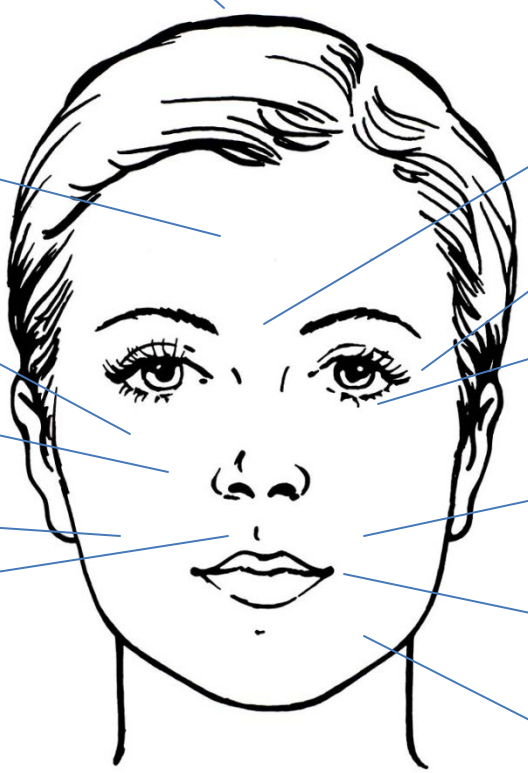
_____ _____ _____ _____

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

Cosmetic Interest Questionnaire (optional)

Manhattan Beach DERMATOLOGY MEDICAL CORPORATION

With respect to facial aesthetics, please mark those areas of the face that bother or trouble you. In the boxes provided please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome). Feel free to draw in the chart to identify any other facial concerns.



☐ Hair loss

Forehead ☐

Freckles and Pigmentation ☐

Blood Vessels ☐

Scarring ☐

Vertical lip lines (smoker lines) ☐

☐ Frown lines

☐ Crow's feet

☐ Dark Circles

☐ Smile Lines (Nose-to-mouth lines)

☐ Oral commissures (Corner-of-the-mouth lines)

☐ Marionette lines (Mouth-to-chin lines)

Larger pores, poor skin texture and fine lines. ☐

Leg Veins ☐

Unwanted hair ☐

Little to no lashes ☐

PRINT NAME_____ DATE_____

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