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Description automatically generated

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

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Description automatically generated

**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\_\_\_\_\_\_\_ Birth sex  Male  Female Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Single  Married  Widowed  Divorced Race\_\_\_\_\_\_\_\_\_ Ethnicity\_\_\_\_\_\_\_\_ Preferred Language\_\_\_\_\_\_\_\_\_\_\_\_

**If patient is a minor, complete parent, or legal guardian information below:**

Cell (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_ Preferred / Home (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_ Preferred / Work (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_ Preferred

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ May we communicate with you via e-mail Yes No

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F/T  P/T  Unemployed

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred pharmacy**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to this office?  Insurance  Friend  Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (doctor’s name and city)

Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

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

Name of Insurance Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Male  Female Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_

Patient’s relationship to policyholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do we have your permission to:**

1. Leave messages on your voicemail regarding confidential info such as biopsy/lab results, billing, etc.?

 Yes  No If YES, please note preferred number:  Cell  Home Work  Other (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_

1. Speak/Disclose your medical condition with any member of your household?  Yes  No

If YES,  same as emergency contact or whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT**

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

Signature **X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

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

**All the above information is true to the best of my knowledge**

Signature **X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Description automatically generated

**Name**\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR TODAY’S VISIT**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height**  **Weight**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 Malignant Melanoma? (not basal cell or squamous cell)**   Yes  No    **If yes, which relative?**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **MEDICATIONS: (Please enter all current medications) None: ** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ALLERGIES: (Please enter all food, medical allergies and their reactions) None: ** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SOCIAL HISTORY:** (Check all that apply) |
| **Drug and Alcohol use Smoking Status**   Drug use  Current every day smoker   IV Drug use  Current some day smoker   Alcohol-none  Former smoker   Alcohol-less than 1 drink per day  Never smoked   Alcohol-1-2 drinks per day **Occupation and Workplace**   Alcohol-3 or more drinks per day  Indoors  Outdoors  **How many times in the past year have you had:**  Men: 5 or more drinks in a day \_\_\_\_\_  Women: 4 or more drinks in a day \_\_\_\_\_\_\_ |
| **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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  None |
|  |

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|  |  |
| --- | --- |
| **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 |  |

**VACCINATIONS:**

Did you receive the flu vaccine this season?  Yes  No

If 65 years or older:

Have you ever received the pneumonia vaccine?  Yes  No

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

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