

JEROME R. POTOZKIN, M.D. | MONICA K. BRAR, M.D. | SAMANTHA ELLIS, M.D.

600 San Ramon Valley Blvd. #102, Danville, CA 94526

TEL (925) 838-4900 FAX (925) 838-4920

PATIENT INFORMATION

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Full Legal Name: _____ Maiden Name: _____
Last First MI

Address: _____
Street City State Zip Code

E-mail Address: _____ Referred By: _____

I give Dr. Potozkin permission to communicate with me via email: Yes No

Ethnicity: Hispanic/Latino Not Hispanic/Latino Unknown Decline to State
Race: White Asian African American Other Decline to State
Language: English Other: _____

Age: _____ Birth Date: _____ Marital Status: _____

Is patient a minor? Yes No Parent/Guardian _____ Relation: _____

(If yes, complete guarantor information below)

Guarantor: _____ Birth Date: _____

Emergency Contact: _____ Relation to Patient: _____ Phone: _____

PRIMARY INSURANCE

Insurance Company: _____ Effective Date: _____ Phone: _____

Address: _____
Street City State Zip Code

Subscriber's Name: _____ ID#: _____ Group#: _____

Relation to Patient: _____ Birth Date: _____

Subscriber's Employer: _____ Occupation: _____ Phone: _____

Employer's Address: _____
Street City State Zip Code

SECONDARY INSURANCE

Insurance Company: _____ Effective Date: _____ Phone: _____

Address: _____
Street City State Zip Code

Subscriber's Name: _____ ID#: _____ Group#: _____

Relation to Patient: _____ Birth Date: _____

Subscriber's Employer: _____ Occupation: _____ Phone: _____

Employer's Address: _____
Street City State Zip Code

PATIENT SIGNATURE

I, certify that I (or my dependent) have insurance coverage with _____ Insurance Company and assign insurance benefits directly to Dr. Potozkin, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature Relationship Date

↓ FOR STAFF USE ONLY ↓

Staff Initials: _____ Date: _____	Staff Initials: _____ Date: _____	Staff Initials: _____ Date: _____	Male
Staff Initials: _____ Date: _____	Staff Initials: _____ Date: _____	Staff Initials: _____ Date: _____	Female

POTOZKIN MD

SKINCARE CENTER

Skin problem(s) today: _____

Do you have, or have you been treated for (circle yes or no)?

Diabetes	YES	NO
Asthma	YES	NO
Seasonal Allergies	YES	NO
Tuberculosis	YES	NO
Hepatitis	YES	NO
HIV	YES	NO
Cold sores	YES	NO

Inflammatory Bowel Disease	YES	NO
Organ Transplant	YES	NO

Pacemaker	YES	NO
Artificial Heart Valve	YES	NO

Skin cancer:

• Basal Cell	YES	NO
• Squamous Cell	YES	NO
• Melanoma	YES	NO

Women only:

• Are you pregnant?	YES	NO
• Are you breastfeeding?	YES	NO
• Plan for pregnancy within 12 months?	YES	NO

Have you had any other medical problems? _____

Medications? _____

Allergies to medications (please list): _____

Are you allergic to:

Tape?	YES	NO	Neosporin?	YES	NO	Bacitracin?	YES	NO
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Has any member of your immediate family (i.e. parent, sibling, or child) ever had?

Melanoma skin cancer	YES	NO	Eczema	YES	NO	Lupus	YES	NO
Asthma or hay fever	YES	NO	Psoriasis	YES	NO	Other autoimmune disease	YES	NO

Social History:

Do you smoke tobacco or use other tobacco products?	YES	NO	Alcohol Use:	YES	NO
Have you ever smoked tobacco or used other tobacco products?	YES	NO	Drinks per week (glasses of wine, beers, mixed drinks)	_____	
Have you used tanning beds?	YES	NO	Daily use of sunscreen?	YES	NO

Review of Systems || Have you had any new/recent (circle yes or no)?

Persistent fevers	YES	NO	Abdominal pain	YES	NO	Persistent Cough	YES	NO
Unintentional weight loss	YES	NO	Headaches	YES	NO	Joint pain	YES	NO

Cosmetic assessment: (This section is *optional*. However, please complete if you are here for a cosmetic consultation.)

Have you previously had (circle YES or NO)?

Botox (or other neurotoxin) injections (YES, NO): If YES, what locations (on face): _____

Filler (ex. Juvederm, Restylane) injections (YES, NO): If YES, what locations: _____

Laser or light treatments (ex. Fraxel, IPL) (YES, NO): If YES, which device and dates: _____

Head or neck surgery (ex. Rhinoplasty, eyelid surgery), please list with dates: _____

Other cosmetic procedures (YES, NO): _____

Do you currently use?

Daily topical antioxidant (ex. Vitamin C serum)	YES	NO	Daily sunscreen (SPF 30 or higher)	YES	NO
Daily topical retinoid (ex. Renova, retinol, tretinoin)	YES	NO	Daily facial moisturizer	YES	NO

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION / SIGNATURE ON FILE
6 Year Consent Form (must be updated if patient is not seen in a 2-year period)

I hereby authorize Dr. Potozkin / Dr. Brar / Dr. Ellis to use and disclose my individually identifiable protected health information ("PHI") in the manner described below. I understand that if the person or entity authorized by this document to receive my Health Information is not a health plan or health care provider, then the disclosed Health Information may no longer be protected from further disclosure by state or federal law.

Messages may be left on my cell / home phone for the following types of appointments: Medical Cosmetic

Detailed messages regarding test results (or) advice may be left on my home answering machine: Yes No

Detailed messages regarding test results (or) advice may be left on my work voice mail: Yes No

Detailed messages regarding test results (or) advice may be left on my cell phone: Yes No

Medical Information can be discussed with: Patient Only Family Member Friend

Name: _____ Relationship: _____ Phone: _____

Medical Information can be released or faxed to my: Physician Insurance Company Pharmacy

Physician's Name: _____ Phone: _____

Account / Billing Information can be released to: Patient Only Family Member Friend Other

Name: _____ Relationship: _____ Phone: _____

I have an advance health care directive: Yes No *We do not honor advanced directives.*

I give Dr. Potozkin / Dr. Brar / Dr. Ellis permission to send a thank you letter to the person who referred me: Yes No

I heard about this practice through: _____

PLEASE READ AND INITIAL

_____ I understand that I am financially responsible for all cosmetic charges at the time of service.

_____ I understand that I am financially responsible for all medical charges whether or not paid by health insurance.

_____ I understand that I am responsible for understanding my medical insurance benefits and coverage.

_____ I understand my medical insurance may not pay for routine labs (or) pathology tests (including biopsies).

_____ By signing, I authorize Dr. Potozkin's / Dr. Brar's / Dr. Ellis's billing service (Aesyntix Billing Solutions) to submit medical claims to my insurance plan(s).

_____ By signing, I authorize Dr. Potozkin's / Dr. Brar's / Dr. Ellis's office to mail to my home any items that assist the practice, such as appointment reminder cards and statements, as long as they are marked *Personal and Confidential*.

_____ I authorize Dr. Potozkin's / Dr. Brar's / Dr. Ellis's office to act as my agent in helping me obtain payment from my insurance company.

_____ I authorize payment directly to Dr. Potozkin's / Dr. Brar's / Dr. Ellis's office.

_____ I have been given the **Notice of Privacy Practices**, a federal privacy law created as a result of Health Insurance Portability and Accountability Act of 1996 (HIPAA), (Revised 9/23/13).

Patient Name (PRINT): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If not signed by patient, please indicate relationship: Parent, if patient is under 18 yrs of age Guardian, if patient is under 18 yrs of age
 Guardian or conservator of an incompetent patient Beneficiary or personal representative of deceased patient

We have a rule in our practice; it's called the "No Jerks Rule". You might have a similar rule in your dealings (we hope so!). Life is too short to work with people who treat you poorly. We only serve patients who are polite, professional and respectful. You can expect us to treat you with dignity and respect at all times. We expect the same, no exceptions.

Thank you for choosing PotozkinMD Skincare and Laser Center for your skin care needs. We are dedicated to providing the best possible care and services for you. Knowing your financial responsibility is an essential element of your care. With healthcare costs shifting to patient responsibility, it is essential you understand your deductible and details of your plan.

Please read carefully and sign at the bottom to confirm your understanding.

- 1) Insurance: your visit is filed with the carrier for whom our practice has a valid contract with. It is the responsibility of the patient to provide *accurate insurance information*. **You will be responsible at the time of service for the payment of copays, unpaid deductibles, and past due balances.**
- 2) Skin cancer screenings are generally NOT covered under your "preventative care benefits." The only cancer screenings covered under the preventative care benefits are: breast, cervical and colorectal cancer screenings. ***Any applicable copays, deductibles and/or coinsurance would apply to skin cancer screening appointments.***
- 3) Self-pay and cosmetic: Payment is expected in full at the time of services.
- 4) Cancellation and Missed Appointments: We understand that unexpected events, illnesses, etc occur. When this happens, call our office as soon possible to inform us of such issues. In the case of missed appointments or cancellations within 24 business hours of the appointment you will be billed a missed appointment fee. ***Cancellations for Monday appointments must be made the Friday morning prior.***
 - a) ***Office Visit- I understand that it is my responsibility to cancel my appointment a minimum of 24 hours in advance of my appointment time and date, otherwise a \$95 fee will be billed to my account which is not covered by my insurance plan.***
- 5) **Credit Card on file:** Recent changes in healthcare markets have altered insurance coverages to shift more of the cost of care to our patients. ***Many policies have higher deductibles which means, even if a procedure is covered by insurance, you may still receive a bill.*** These external factors make it necessary for PotozkinMD Skincare and Laser Center to maintain a credit card on file for all patients. The card information is stored with security--the same HIPAA compliant software that protects your confidential medical information. ***Should you have a balance after your visit, we will bill the card on file. By signing this form you authorize PotozkinMD Skincare and Laser Center to bill your card on file.*** Receipt of any transaction will be emailed at the time of the charge.
- 6) Methods of payment accepted are: Cash, Visa, Mastercard, Discover and personal checks with proper identification (valid Driver's license or photo ID). A \$30.00 overdraft charge will be added to the insufficient funds amount of any returned checks.

I have read the above financial policies and understand my financial responsibilities as a patient. I understand that failure to make payment when due is the basis for legal action and agree to pay all costs of collection, including court costs and attorney fees.

Patient Name (please print) : _____

Patient or Guardian signature: _____ Date: _____