Dr. Leila Ettefagh

Advanced Dermatology
210 S. Grand Ave. #208
Glendora, CA 91741
(626) 914-3675 Fax (626) 914-3525

Dr. Navid Nami

Patient Information

Name _____ Driver's Lic. # _____
Last First Initial

Address _____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone_____ Work Phone _____

Best Phone Number to call for appointment reminders and results: Home / Cell **TEXT REMINDER** ___ YES ____ NO

Sex: M_____ F _____ Birth date _____ Maiden Name_____

Patient Employed By_____ Business Address _____

Name of Spouse _____ Spouse Cell Phone _____

In case of emergency, who should be notified? _____ Phone _____

If visiting from out of town, please provide a local phone number _____

Referred by: Doctor_____Friend/Relative_____ Other _____

Would you like to receive Island Dermatology Newsletters via email _____YES _____ NO
Email Address: _____

Primary Insurance

Subscriber Name _____
Last First Initial
Subscriber Birth date_____ SSN #_____ Relation to Patient_____

Secondary Insurance

Is Patient covered by additional insurance? Yes_____ No_____

Subscriber Name _____
Last First Initial
Subscriber Birth date _____ SSN #_____ Relation to Patient_____

Acknowledgement of Receipt of Notice of Privacy Practices

Island Dermatology reserves the right to modify the privacy practices outlined in this notice.

I have reviewed or received a copy of the Notice of Privacy.

_____
Name of Patient (please print)

_____ _____ _____
Signature of Patient/If Patient is a Minor /signature of Patient Representative **Relationship to patient** **Date**

Please note that State and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.

Name of Person Completing this form _____ Date_____

A signed Financial Agreement is also required prior to treatment

ADVANCED DERMATOLOGY
PRACTICE/PATIENT FINANCIAL AGREEMENT

Patient Name: _____ Date: _____
(Please print)

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask you adhere to the following guidelines:

1. Proof of Insurance and Photo ID are required for all patients.

2. It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.

3. **It is your responsibility to contact your insurance carrier to confirm that our physicians participate in your plan as well as to know your benefit levels (Deductibles, co pays). If you see a doctor that is not currently on your plan, you will be responsible for payment in full. Please be advised it is Your responsibility to request what charges will be sent to insurance Prior to services performed. At that time a quote will be provided for what will be billed to insurance we are Unable to to advise of your final patient responsibility until claim has been processed by your insurance,**

4. In order to schedule a surgical procedure we will collect in advance any **unmet** deductibles/co-insurance that are set forth by your insurance.
   - **Payment in full on any patient balance is expected at check-in.**
   - **$10.00 service fee will be charged for failure to pay copayment at time of service.**

6. If you miss your appointment or do not cancel within **24 business hours** you will be charged a **$25.00** fee that will be due **prior** to rescheduling a new appointment.

7. All medical record requests must be in writing and received in our office 72 hours prior to the date needed;**$15.00** records copying fee required for charts larger than 10pgs.

8. The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

9. **Parent/Guardian must be present for first visit.**
   For unaccompanied minors, non-emergency treatment will be denied unless consent for treatment is on file and payment arrangements have been made and verified to be on file in advance.

10. **PPO/POS/EPO Patients**; please be aware that for biopsy specimens it may be necessary to utilize an "**Outside Laboratory**". You will receive a separate bill from them in addition to a bill from us for services rendered. Patient to advise our office of their Lab preferences **prior** to procedures; we will do our best to accommodate lab choice.

I have read and understand the Financial Policy set forth by Island Dermatology.

For Minor Patients, Responsible Parties Name_____Relationship_____

Patient or Responsible Parties Signature _____ Date_____

Advanced Dermatology

Medical History Form

Patient Name_____ **Date**_____

Reason for today's visit: _____

Primary Care Physician (PCP) _____

Who can we thank for referring you to our office:_____

Allergies to Medications: _____ None _____

Current Medications: _____ None _____

SKIN CANCERS (Please Circle)

History of Skin Cancer? **NONE** Melanoma / Squamous Cell / Basal Cell / **If Yes Location:** _____

Family history of Skin Cancer? **Yes / No** Family history of Melanoma? **Yes / No**

SYMPTOMS Are you having any symptoms today? (Please Circle)

Headache	Diarrhea	Abdominal Pain
Nausea/Vomiting	Cough	Dizziness
Shortness of Breath	Chest Pain	Fever / Chills
Irregular Heartbeat	Vision Loss	**NONE OF THE ABOVE**

PAST MEDICAL HISTORY (Please Cirlce)

High Blood Pressure	Diabetes	Heart Disease	HIV/Hepatitis B/C
Artificial Heart Valves	Artificial Joints	Blood Clots	Brain Stunt
Glaucoma	Kidney Disease	Emphysema	Thyroid Disease
Pacemaker	Automated Defibrillator	Mitral Valve Prolapse	**NONE OF THE ABOVE**

PAST SURGERIES:

History of Organ Transplants- Kidney/Liver/Lung/Heart

Y	**N**			
__	__	Do you pass-out easily with medical procedures		
__	__	Do you scar / keloid easily		
__	__	Do you require antibiotics prior to surgery		
__	__	Do you drink alcohol	If yes:	_____Occasional ____Daily
__	__	Do you smoke	If yes:	_____ packs per day
__	__	Do you use or have ever used intravenous drugs		
__	__	Do you have any **Latex** allergies		
__	__	Have you ever had any adverse reaction to Dental Anesthesia		
__	__	Are you Pregnant		
__	__	Are you Breast feeding		

Occupation_____

Preferred Pharmacy/Location_____

Patient Signature_____ Physician Signature_____

Advanced Dermatology Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payments: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you have used to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Health care operations: Your health information may be used to support the day-to-day activities and management of Advanced Dermatology. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement: Your health information may be disclosed to law enforcement agencies without your permission to support government audits and inspections to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not effect or undue any use or disclosure of information that occurred before you notified us of your decision. Additional uses of information include:

Appointment reminders: Your health information will be used by our staff to send you appointment reminders.

Information about treatments: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing our health-related goods and service that we believe may interest you.

Individual Rights: You have certain rights under the federal privacy standards. These include:

The right to request restrictions on the use and disclosure of your protected health information.

The right to receive confidential communications concerning your medical condition and treatment.

The right to inspect and copy your protected health information.

The right to amend or submit corrections to your protected health information.

The right to receive an account of how and to whom your protected health information has been disclosed.

The right to receive a printed copy of this notice.

Advanced Dermatology Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information: As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may request a form to obtain access to your records by contacting Advanced Dermatology.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to Advanced Dermatology, 210 S Grand Ave Suite 208 Glendora, CA 91741. Telephone (626)914-3675

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. You can contact Advanced Dermatology for further information concerning our privacy practices.

Effective Date: This notice is effective on or after September 1, 2012.