SIGNATURE PAGE for _____

(Please Print Patient Name)

Release of Medical Information

I authorize the release of medical information to my primary care physician and to his/her consultants if needed, and to process insurance claims, insurance applications, or to complete any other medical operations as necessary. I additionally authorize the sharing of medical information between Med-X Healthcare, Inc. as necessary for my care.

Signature: _____ *Date:* _____

Financial Policy – All Patients, Including Medicare

Payment is required for all services at the time they are rendered unless you are have set a prepaid plan in which we participate. For those patients, applicable co-payments, co-insurance and deductibles will be collected. All medical procedures performed have separate fees in addition to an office visit fee. Our office **does not** accept Cal-Optima/Medi-Cal/Medicaid, HMO plans, any workers' compensation cases, some PPO insurance plans, and may not accept other plans. **Please, also, be advised that we do not accept any plans under the Affordable Care Act or Covered California. Patients are responsible to check our participation with their plan before their visit. The patient is responsible for any and all charges not paid for by their insurance company.** ***If you must cancel or reschedule an appointment, please do so at least 48 hours before the scheduled appointment time. A charge ranging from $50 to $100 may be applied to patients who miss their appointment or do not notify the office of a cancellation 48 hours in advance, depending on the time allotted for that specific appointment.***

I have read and understand the financial policy statement. I agree to make in-full prompt payment when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Furthermore, I authorize payment directly to Medx Health Care for medical insurance benefits payable to me under the terms of my policy. This authorization is valid until revoked in writing. ***The SIGNER must complete THEIR OWN information here:***

Signature: _____ *Date:*_____

Financial Policy – Medicare Patients Only

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare, or its intermediaries of carrier, any information needed for this or a related Medicare claim. I permit a copy of their authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Signature: _____ *Date:*_____

Privacy Practices (HIPAA)

Notice of Privacy Practices

- A copy of this notice is available to you. Please ask the reception staff if you would like one. By signing below, I acknowledge that I have been offered a copy of our Notice of Privacy Practices.
- By signing below, I authorize MedX to leave a detailed message in reference to any items that assist the practice in carrying out healthcare operations.

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ *Date:* _____

PATIENT INFORMATION

Name: _____
Last *First* *M.I.*

Address: _____
Street *City* *State* *Zip*

Home Phone: (_____)_____(_____) _____(_____)_____
Home *Mobile* *Work* *ext*

Date of Birth: _____ **Sex**: M☐ F☐ **Social Security Number**: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Patient Race: ☐ White ☐ Hispanic ☐ Asian ☐ Black or African American
☐ Native Hawaiian ☐ Pacific Islander ☐ Other Race

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Preferred Language**: ☐ English ☐ Spanish ☐ Other: _____

EMPLOYMENT STATUS: ☐ Full Time ☐ Part-Time ☐ Self-Employed ☐ Retired

Employer Name: _____

Employer Address: _____
Street *City* *State* *Zip*

Primary Care Physician: _____**Telephone**: (____)_____

How did you find us?

☐ Physician (Name : _____) ☐ Family or Friend (Name : _____)

☐ Yellow Pages ☐ Insurance Book ☐ Internet ☐ Newspaper Ad ☐ Other: _____

Emergency Contact Name: _____**Relationship:** _____

Emergency Contact Home Phone: (____)_____ **Emergency Contact Work Phone:** (____)_____

Patient E-mail Address:_____

Pharmacy Name & *LOCATION*: _____**Pharmacy Telephone:**_____

INSURANCE INFORMATION

Please check one:

☐ **Self Pay** *(no insurance)* ☐ **Patient IS the policy holder** ☐ **Patient IS NOT the policy holder** *(fill out below)*

If the above named patient is not the primary policy holder, please fill out the following:

INSURED INFORMATION

Name: _____
Last *First* *M.I.*

Date of Birth: _____ **Social Security Number:** _____ **Sex:** ☐ M ☐ F

Address: _____

Telephone: (____)_____(____)_____(____)_____
Home *Mobile* *Work* *ext*

MEDICAL QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **Date:** _____

Reason for Visit: _____

Do you have or have had any of the following? *(if yes, please check)*

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Artificial heart valve
- ☐ Artificial Joints or metal implant
- ☐ Atopic Dermatitis
- ☐ Atrial Fibrillation
- ☐ Atypical moles
- ☐ Auto immune disease (lupus, rheumatoid arthritis)
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Chronic Fatigue or Fibromyalgia
- ☐ Cold sores / herpes
- ☐ Depression
- ☐ Diabetes
- ☐ Down's Syndrome
- ☐ Heartburn / Ulcers/ Gastritis / Reflux
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV
- ☐ Keloids or scarring problems
- ☐ Kidney disease
- ☐ Liver disease or hepatitis
- ☐ Lung disease
- ☐ Melanoma
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ pacemaker
- ☐ Psoriasis
- ☐ Reactions to local anesthesia
- ☐ Seasonal allergies / asthma
- ☐ Seizures
- ☐ Stroke
- ☐ Skin cancer (basal or squamous cell carcinoma)
- ☐ Cancer, other
  Please list:
- ☐ Thyroid trouble
- ☐ Other conditions
  Please list:

Please list any medications, herbal supplements, and/or vitamins you are currently taking:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes No *(if yes, please list medication and reaction)*

Medication: _____Reaction:_____Medication:_____Reaction:_____

Medication: _____Reaction:_____Medication:_____Reaction:_____

Please list major surgeries:

_____Date: _____ _____Date:_____

_____Date:_____ _____Date:_____

_____Date:_____ _____Date:_____

Please list major hospitalizations:

_____Date:_____ _____Date:_____

_____Date:_____ _____Date:_____

Please list any relatives (mother, father, grandmother, grandfather, brother, sister) **that have had any of the following conditions:**

- ☐ Skin cancer: _____
- ☐ Eczema: _____
- ☐ Melanoma: _____
- ☐ Diabetes: _____
- ☐ Elevated Cholesterol: _____
- ☐ Seasonal Allergies: _____
- ☐ Psoriasis: _____
- ☐ Autoimmune Disease: _____
- ☐ Cancer: _____
- ☐ Other:_____

How many do you have of the following? Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

Do you take Coumadin or other blood thinners:	Yes	No
Do you take Aspirin daily?	Yes	No
Do you need antibiotics before surgery or dental work?	Yes	No
Are you pregnant or nursing?	Yes	No
Are you allergic to any local anesthetic?	Yes	No
Do you exercise?	Yes	No
Do you drink alcoholic beverages?	Yes	No
If so, how much (number of beverages / week)?	_____	

What is your occupation? _____

Tobacco Use *(please check one category)*

- ☐ Never a smoker
- ☐ Former smoker. If yes, how long has it been since you last smoked?
  - ○ <1 month 1-3 months 3-6 months 6-12 months 1-5 years 5-10 years >10 years
- ☐ Current smoker. If yes:

  How often do you smoke cigarettes? *(Please check one)*
  - ○ Every day ○ Some days, but not every day

  How many cigarettes a day do you smoke? *(Please check one)*
  - ○ 5 or less ○ 6-10 ○ 11-20 ○ 21-30 ○ 31 or more

  How soon after you wake up do you smoke your first cigarette?
  - ○ Within 5 minutes ○ 6-30 ○ 31-60 ○ after 60 minutes

  Are you interested in quitting? *(Please check one)*
  - ○ Ready to quit ○ Thinking about quitting ○ Not ready to quit

Have you recently had any of the following? *(Please check all that apply)*

- ☐ Weight change
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Headache
- ☐ Vision changes
- ☐ Ringing in ears
- ☐ Recurrent nosebleeds
- ☐ Neck stiffness
- ☐ Enlarged glands
- ☐ Sore throat
- ☐ Chest pain
- ☐ Palpitations
- ☐ Leg swelling
- ☐ Shortness of breath
- ☐ Cough
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in urine
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Heat / Cold intolerance
- ☐ Change in hair pattern
- ☐ Easy bruising
- ☐ Abnormal bleeding
- ☐ Seizures
- ☐ Irregular menstrual cycles
- ☐ Depression
- ☐ Nervousness

Patient Name: _____ Date: ____/____/____

How did you hear about us?

❑ My physician **Name:**
❑ Advertisement **Please Specify:**
❑ A friend or family member **Name:**
❑ Website (Yelp, Google, etc.) **Please Specify:**
❑ www.medxladera.com
❑ Other **Please Specify:**

❑ Approval to contact you.	*Best phone number to reach you: ( ) -*
❑ Approval to send you information on products and services (including special offers)	***Email address:***

What additional services would you like to learn about? (please check all that apply)

❑ Skin care products	❑ Facial veins/redness	❑ Abdominal area
❑ Facial Injectable/ Fillers	❑ Brown spots/age spots/sun spots	❑ Hips
❑ Facial fine/deep lines	❑ Drooping brow	❑ Legs
❑ Thin lips	❑ Drooping eyelids	❑ Facial Contouring
❑ Length of Eyelashes	❑ Facial fullness/drooping	❑ Body Contouring
❑ Chemical peel	❑ Neck wrinkles	❑ Unwanted Hair
❑ Blotchy skin	❑ Eczema	❑ Other: _____
❑ Acne	❑ Psoriasis	

❑ *I'm not interested in any additional services provided at this time*

Thank you for completing this questionnaire so that we may provide all services needed to take care of your interests or concerns.

Financial Responsibility Policy

At Medx Dermatology, one of our missions is to provide the highest quality experience and results. In order to achieve this we have implemented a new credit card policy.

You will be asked for your credit card at the time of scheduling an appointment and this information will then be held securely on our federally protected EMR (Electronic Medical Record) system. Your account will be charged when we receive your responsibility amount from insurance or if you late cancel or no-show any appointment within 48 hours of your scheduled appointment.

This will be an advantage to you since you will no longer have to write out checks or statement slips and mail them in. **This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.**

Co-pays will be due at the time of service which we will ask of you in person.

If you have any questions about this payment method please feel free to ask any member of our staff to clarify it for you.

By signing below I have authorized Medx Health Care Inc. and its associates to charge any outstanding balances on my account to the following credit/debit card:

_____ _____

Please PRINT Name Date

_____

Patient Signature

_____ _____

Date

Credit Card Payment Authorization Form

Sign and complete this form to authorize Medx Health Care Inc. to make a debit to your credit card listed below.

By signing this form you give us permission to debit your account for the amount indicated for fees accrued for no-showing or late cancelling an appointment within 48 hours of your appointment or any balance left unpaid. ***This information is stored in your personal EMR (Electronic Medical Record) and is federally protected by HIPAA.***

Please complete the information below:

I _____ authorize Medx Health Care Inc. to charge my credit card
(please PRINT full name)

account indicated below for any balance on or after your initial visit date to our practice. This payment is for goods/services provided by Medx Health Care Inc.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____ Billing Zip Code _____

CVV2 (3 digit number on back of Visa/MC, 4 digits on front of AMEX) _____

SIGNATURE _____ DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

CANCELLATION POLICY

Dear Patient,

Thank you for trusting your medical and cosmetic care with MedX Health Care. We strive to render excellent service to you, your family, and all of our patients. In order to be consistent with this philosophy, MedX Health Care uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs.

If you are unable to make your appointment, or notify us of your inability to keep your appointment by phone at least 48 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient. We understand emergencies happen and will be more than happy to waive any associated fees.

Our policy is as follows:

1. We request that you please give our office a 48-hour notice in the event that you need to reschedule or cancel your appointment. This will make the appointment time available to someone else.

2. If you miss an appointment or do not contact our office with at least a 48-hour prior notice, we will consider this to be a missed appointment and a fee *ranging from $50.00 to $100.00, depending on the time allotted for your appointment*, will be assessed to you.

3. If you are late for an appointment, you will be seen as soon as possible, though your office visit may need to be shortened in length.

4. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

If you have any questions regarding this policy, please call our office at (949)481-8881 and we will be glad to address those for you.

We sincerely thank you for your patronage. We are happy to have you as our patients.

I have read and understand the cancellation policy for MedX Health Care and agree to be bound by the terms.

_____ _____

Signature (Parent / Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date