Please Return This Document to the Front Desk

PATIENT MEDICAL HISTORY

Beverly Hills Skin Care Institute

TODAY'S DATE:

PATIENT NAME:

DATE OF BIRTH:

1) A. How were you referred to our office?
   B. Briefly, what is the reason for your visit?
   C. Is this your first visit to a Dermatologist?
2) Have you ever been hospitalized or had surgery? If yes, for what reason?
3) What Drugs are you allergic to? Other allergies?
4) Please list all over-the-counter and prescription medications you are currently taking:

Name/Reason For Taking

Name/Reason For Taking

5) Do you have a pacemaker, irregular heart rate, heart murmur, or mitral valve prolapse?
6) Do you have any artificial joints, heart valves, or other prosthetics?
7) Do you require pre-medication with antibiotics before dental appointments?
8) Are you pregnant or planning pregnancy in the near future?
9) Are you diabetic?
10) Are you being treated for high blood pressure or heart disease?
11) Have you ever had rheumatic fever, hepatitis, or tuberculosis?
12) Have you ever been diagnosed as having epilepsy or seizures?
13) Have you ever been diagnosed with collagen or autoimmune diseases?
14) Are you HIV positive or do you have AIDS?
15) Do you have ulcers?
16) Have you ever had cold sores or another type of herpes virus?

17) Do you have photosensitivity?

18) Have you ever had skin cancer or any other skin diseases? If yes, what type?

19) Do you have any other disease or condition not previously listed? (asthma, thyroid, cancer, etc.)?

20) Is there a family history of skin cancer or skin disease? If yes, what type?

21) Is there any other family history or other conditions that we should know about?

22) Do you use tobacco? How frequently and amount?

23) Do you drink alcohol? How frequently and amount?

24) What are your hobbies? Do they expose you to any chemical irritants?

25) What is your occupation?

26) How are you feeling in general today?

27) Do you have any special requests related to your visit today or any special concerns?

28) What is something that you like people to know about you?

<u>Additional information or comments:</u>

Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION – PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City: , State:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex:
Date of Birth:
Social Security No.:
Patient email:

Guarantor Information (to whom statements are sent)

Name:
Address:

Relationship to patient: ___________________________
Date of Birth:
Social Security No.:
Phone: ( ) _______ - _______________

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:( ) _______ - _______________

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth:, Sex (please circle): **M** or **F**
Employer Name:

Policy Information

Patient's relationship to policy holder:
ID/Certification No.:
Policy/Group No.:

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **A fee for no shows may apply.**

Signed____ **Date:**____________________

SAMPLE: To be reviewed and approved by Internal Counsel prior to use

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name | Date of Birth | Social Security Number

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with MI State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. INDIRA C. MISRA HIGGINS, DO PLLCuses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to INDIRA C. MISRA HIGGINS, DO PLLC.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to INDIRA C. MISRA HIGGINS, DO PLLC
3. I have the right to revoke this authorization at any time by writing to INDIRA C. MISRA HIGGINS, DO PLLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE INDIRA C. MISRA HIGGINS, DO PLLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law | Date

Relationship to Patient | Interpreter, if utilized

Witness Signature

Please Return This Document to the Front De...

Beverly Hills Skin Care Institute

HIPAA Privacy Notice Receipt Acknowledgement

Patient Name:

Patient DOB:

I have received the HIPAA Notice of Privacy Practice for Beverly Hills Skin Care Institute.

____

Printed Name

______________________________	_________
Signature of Acknowledgement	Date
______________________________	_________________
Name if you Represent the Patient	Relationship

Current Financial Policy for Beverly Hills Skin Care Institute

Effective Date: *May 1st, 2024*

Introduction
Welcome to Beverly Hills Skin Care Institute. We are committed to providing you with the highest quality dermatological care in an efficient and effective manner. Our financial policy is designed to clarify our expectations regarding payment and to help you understand your responsibility regarding the services received at our clinic.

Payment Policy

Insurance: We participate in most major health insurance plans, excluding medicaid. **It is your responsibility to:**

1. Bring your current insurance card and a valid ID to every visit.
2. Pay any co-payments, deductibles, or coinsurances at the time of service or upon receipt of your statement. **We are required by your insurance carrier to collect any charges which they determine to be the patient's responsibility**.
3. Ensure referrals and pre-authorizations are obtained before your visit if required by your insurer. **Our office is not responsible for any outstanding balances that result from patients' failure to obtain a referral or authorization for services from the insurance carrier prior to the claim being submitted**.

Self-Pay Patients or Patient with Medicaid

If you do not have insurance coverage, payment in full is required at the time of service. We offer a discount for services paid in full on the day of the visit. **New patient office visits are $125**, not including additional procedures or services. **Return office visits are $80**, not including additional procedures or services. Fees for any additional services or treatments can be discussed prior to scheduling an appointment or at the time of the visit. Often, these fees are based on the diagnosis and treatment plan necessary.

Forms of Payment: We accept cash, checks, and major credit cards. Returned checks will incur a fee of $25.

Billing Statements:

If you have a balance after your insurance has issued their payment or denial, we will send you a statement. This balance is due upon receipt of the statement.

<u>Collections:</u> Accounts with an outstanding balance of more than 180 days will be forwarded to a collection agency. You will be responsible for all costs incurred in collecting unpaid balances including collection agency fees, attorney fees, and court costs.

Cancellations and Missed Appointments
We require at least a 24-hour notice to cancel or reschedule an appointment. Failure to cancel or reschedule at least 24 hours in advance will result in a fee of $50 to $75, which the patient will be responsible for paying.

Late Fees
Payments that are 90 days overdue will accrue a $45 late fee. After 120 days, another fee of $75 will be charged to the account. At this point, your account is at risk for being sent to collections.

Additional Services
Some services provided may be non-covered or not considered necessary under Medicare or other insurance programs. Consequently, you may be responsible for full payment of these services.

Consent to Treat and Financial Agreement
By signing below, you agree to accept full financial responsibility as a patient who is receiving care at our clinic. You confirm that you understand and agree to abide by this financial policy, which may be amended from time to time.

Print Name: ______________________________
Acknowledgement Signature: ________________________
Date: ____________________

Insurance Policy Form for Beverly Hills Skin Care Institute

Effective Date: May 1st, 2024

Authorization and Assignment

I give Beverly Hills Skin Care Institute permission to share details of my treatment with insurance companies. I also entrust the dermatologist with handling all claims for medical services for me or my dependents. I understand that I am liable for any costs not covered by insurance.

Insurance Verification

I understand that verification of insurance eligibility is not a guarantee of payment and that I am ultimately responsible for the payment of my account. It is my responsibility to inform the clinic of any changes in my insurance coverage. I acknowledge that it is also my responsibility to understand my insurance benefits, coverage, and if a referral or authorization is needed prior to my visit. I assume all responsibility for any outstanding balances that result from a failure to abide by this policy.

Financial Agreement

I agree that I will be responsible for any charges incurred if the insurance benefits result in less coverage than anticipated. I understand that charges may include non-covered services and services deemed not medically necessary by the insurance company.

Acknowledgment of Insurance Policy

I have read and understood the insurance policy of Beverly Hills Skin Care Institute and agree to adhere to all its requirements and provisions. I agree to bring my insurance card to each visit and notify the clinic of any changes in my insurance information.

Patient Name: ______________________

Patient's Signature:_____________________________

Date:____________________

Policyholder's Signature (if different from patient):_____________________________

Date:____________________

Referral and Prior Authorization Policy for Beverly Hills Skin Care Institute

Effective Date: May 1st, 2024

Introduction

At Beverly Hills Skin Care Institute, we strive to provide our patients with the best possible care. To facilitate this, certain health insurance plans require referrals from primary care physicians (PCPs) and prior authorizations for specific treatments and procedures. This policy outlines our office procedures and patient responsibilities related to referrals and prior authorizations.

Requirement of Referral:

Patients enrolled in HMOs or other plans that require a referral from a PCP must obtain this referral before scheduling an appointment.
It is the patient's responsibility to understand the terms of their insurance coverage and to ensure a valid referral is provided to our office prior to the visit.

Obtaining a Referral:

Patients must contact their PCP to request the necessary referral. A valid referral contains the appropriate information, the correct date of the appointment, and confirmation that insurance has been notified.
Ensure that the referral is sent to our office either through electronic health records or delivered physically by the patient at the time of the visit.

Failure to Provide Referral:

If a patient arrives without the required referral, the appointment may be rescheduled until the referral is obtained. If the patient wishes to be treated without a referral on file, *it is the patient's responsibility to understand that insurance will not cover the visit and they will be required to pay out of pocket for any charges that are billed.*

Requirement of Prior Authorization:

Certain procedures and treatments require prior authorization from the insurance provider. This includes, but is not limited to, advanced dermatological surgeries, specific medications, and cosmetic procedures.
Our office is happy to assist in submitting requests for prior authorization **if proper notice is given**; however, obtaining approval is ultimately the responsibility of the patient.**Our office is not responsible for knowing a patient's insurance coverage therefore the patient acknowledges that they will be required to pay for all outstanding charges.**

Processing Time:

Patients and referring physicians should be aware that obtaining prior authorization can take several days to weeks depending on the insurance provider and the specific request.

Patients are advised to check with our office to confirm authorization has been received before proceeding with scheduled procedures.

Patient Responsibilities

It is crucial for patients to actively participate in managing their referrals and prior authorizations. This includes communicating with their insurance company and primary care physician, as well as our office, to ensure all paperwork is completed and submitted in a timely manner.

Conclusion

We thank you for your cooperation and understanding regarding our referral and prior authorization policy. Our goal is to provide you with timely and effective dermatological care while complying with the requirements set forth by your health insurance providers.

Acknowledgement:

I have read and understood the Referral and Prior Authorization Policy of Beverly Hills Skin Care Institute and agree to comply with the terms as described.

Patient Name: ______________________

Patient Signature: _________________________
Date: ___________________