VIDA | VENTURA INSTITUTE OF DERMATOLOGIC ARTS

Peter L. Karlsberg, MD, FAAD & Michele Ayans, PA-C

Date: _____ Social Security Number: _____-_____-_____

Patient Name: _____

(Last) (First) (Middle)

Address: _____

(Street) (Apt) (City) (State) (Zip)

Date of Birth: _____ Age: _____ Driver's License #: _____

Male ☐ Female ☐ Marital Status: S M D W Occupation: _____

Employer: _____

PATIENT DISCLOSURES & COMMUNICATIONS

We take great care to protect your privacy. In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Cell #: _____ May we text you on this line? ☐ Yes ☐ No

☐ OK to text ☐ OK to leave detailed voice/text message ☐ Leave call-back number only

Email Address: _____

☐ Do NOT email me with appointment information (no medical information – just date/time/location)

☐ Do NOT email me specials once a month (one-click unsubscribe so you can change this later)

Home #: _____ ☐ OK to leave message ☐ Leave call-back number only

Work #: _____ ☐ OK to leave message ☐ Leave call-back number only

Preferred contact method: ☐ Text ☐ Email ☐ Call- Home ☐ Call- Cell ☐ Call- Work

Patient Signature _____ Date _____

Print Name _____ Birthdate _____

List anyone below with whom you give us consent to share your protected health information (PHI).

NAME RELATIONSHIP PHONE

_____

_____

Emergency Contact: _____ **Phone** _____

Relationship to Patient: _____

Referred by: ☐ **Family** ☐ **Friend** ☐ **Doctor** ☐ **Facebook/Social Media** ☐ **Website** ☐ **Yelp**

☐ **Google or a search engine** ☐ **VC Reporter** ☐ **Other** _____

If you wrote friend or family member, who specifically? _____

Referring Physician _____ Primary Physician _____

Primary Insurance _____

Subscriber Name _____ Subscriber DOB: _____

Secondary Insurance _____

Subscriber Name _____ Subscriber DOB: _____

PLEASE PROVIDE YOUR INSURANCE AND ID CARDS TO THE RECEPTIONIST

IMPORTANT

DUE TO INCREASES IN OUR CASE LOAD, WE HAVE MADE CHANGES TO OUR NO SHOW POLICY. THIS IS TO ENSURE QUALITY AND TIMELY CARE FOR ALL OF OUR PATIENTS. PLEASE READ THE NEW POLICY AND SIGN BELOW.

NO SHOW & LATE CANCELLATION POLICY: As a courtesy, reminder phone calls, texts, or emails are usually sent out 24 - 72 hours in advance of your scheduled appointment. If you are unable to keep your scheduled appointment time, we require at least 48 business hours notice (2 weekdays) so that we may accommodate others who need to be seen. In the event you do not provide us with 48 business hours notice, a $50 non-refundable fee must be paid before further appointments can be scheduled. A second "No Show" or "Late Cancellation" will result in a $75 fee before further appointments can be scheduled. In the event of a third "No Show" or "Late Cancellation," you will be required to seek dermatological services elsewhere, as patients often wait weeks to receive our care, some of whom have serious problems.

Please sign below to indicate that you understand the Late Cancellation and No Show policies and fees above.

_____ _____ / / _____

Signature of Patient/Legal Guardian Date

INSURANCE PAYMENT POLICY

Contracted Private Insurance: We contract or participate in many private insurance company programs, including, but not limited to Blue Shield, Blue Cross, Cigna, United Healthcare, Tri-Care and/or Gold Coast Benefits. If you are a member of one of the plans with whom we contract, we will accept payment at the level allowed by your program (except if you have multiple insurances), although you will be responsible for any deductible, co-payment or co-insurance required. Necessary adjustments to our billed charges will be made after payment is received from the payer. **We are not a participating provider with ANY Covered California or affiliated insurances.**

Other Private Insurance: We will assist you by billing your primary insurance company. If you have a secondary insurance, we will bill it as a courtesy. However, you are responsible for all charges billed to you. We reserve the right to ask you to pay a deposit before services are rendered. We find that most insurance only covers a portion of your medical expenses, and you will have some balance to pay.

Medicare Patients: This office is a participating Medicare physician's office. As such, Medicare patients will only be required to pay the difference between what Medicare allows and the amount paid by Medicare, which is the Medicare co-insurance and deductible. Necessary adjustments in our billed charges will be made after payment from Medicare is received. **Medi-Cal Patients:** Our office does not accept Medi-Cal patients/payments.

Co-Payments & Deductible: If your health plan requires a co-payment, please be prepared to make the appropriate payment the time of service. If you have a commercial insurance and have not met your deductible for the year, a prepayment of up to $500 may be required for any procedure.

Cosmetic and Cash Patients: Patients that are seen for cosmetic procedures or patients who do not have insurance will be expected to pay for their procedures **prior** to their departure from this office. In some cases, patients will be asked to pay in advance.

FINANCIAL RESPONSIBILITY

If your insurance information is not available at the time of visit, your appointment will need to be rescheduled. NO EXCEPTIONS.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. You are responsible for the bill. Our office files insurance claims as a courtesy. It is the patient's responsibility to know your insurance coverage. Some companies pay fixed allowances for certain procedures; others pay a percentage of charges. For insurances with which we contract, we will adjust your balance due according to our contract with the insurance carrier. It is your responsibility to pay any deductible, co-payment, co-insurance, and any balance not paid by your insurance that we are not required to adjust.

It is your responsibility to provide us with all information we may require to properly submit claims on your behalf. We will work with your insurance company within reason. However, you are responsible for charges for service you incur. Should you have any questions, please feel free to discuss them with a member of our billing staff.

All balances are due upon delivery of the billing statement showing your balance. You may pay by cash, check, Visa, or MasterCard. If your account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees and cost of collection. PLEASE BE ADVISED THAT AS OF 07/01/03, ALL ACCOUNTS THAT ARE 60 DAYS PAST DUE WILL HAVE A PERIODIC RATE OF 0.84% INTEREST ADDED PER MONTH TO THEIR ACCOUNT BALANCE (ANNUAL PERCENTAGE RATE OF 10%)

RETURNED CHECK FEE: $40

I certify that I have read the Insurance Payment Policy and Financial Responsibility statements, and understand their contents. I understand the above Financial Policy and will take full responsibility for my bill if insurance does not cover or pay for the services performed within 90 days.

_____ _____ / ____ /

Signature of Patient/Legal Guardian Date

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I may be entitled from an insurance plan(s) to Ventura Institute of Dermatologic Arts (Peter L. Karlsberg, M.D.). This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance or third-party payer. I hereby authorize said assignee to release all information necessary to secure payment of benefits.

Signature of Patient/Legal Guardian _____ Date ____/____/____

CONSENT TO RELEASE INFORMATION

I hereby authorize Ventura Institute of Dermatologic Arts (Peter L. Karlsberg, M.D.) to furnish information to any referring physician, agency, or insurance company (s) I have listed on the Patient Information Form.

Signature of Patient/Legal Guardian _____ Date ____/____/____

MEDICARE ASSIGNMENT - *If you have Medicare, please sign the following:*

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Ventura Institute of Dermatologic Arts (Peter L. Karlsberg, M.D.) for any services furnished me by him or an affiliated supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA-1500 claim form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determinations of the Medicare carrier.

Signature of Patient/Legal Guardian _____ Date ____/____/____

CONSENT TO TREAT

I hereby authorize and give my permission to the employees and agents of this medical office to render any medical treatment including but not limited to, examination, injections, biopsy, diagnostic testing, treatment with liquid nitrogen or medical procedures (as deemed advisable by Peter L. Karlsberg, MD, FAAD, and the members of Ventura Institute of Dermatologic Arts staff. I further acknowledge this may include seeking a second opinion for pathology interpretation/results. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, I will not be provided medical care. **All minors must be accompanied by a legal guardian on their initial visit to our office.**

Signature of Patient/Legal Guardian _____ Date ____/____/____

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.

Uses and Disclosures

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 lab 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.

Payment. 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 may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Peter L. Karlsberg, M.D., A Medical Corporation [DBA: Ventura Institute of Dermatologic Arts]. For example, information on the services you received 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 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 or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Additional Uses of Information

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 that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Marketing. Unless you request us not to, there are some marketing activities that we may use your name and address for, to provide you with information about services available at our practice. If you'd rather not receive marketing communication from our practice, please leave the box blank on the Patient Disclosures form.

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 accounting of how and to whom your protected health information has been disclosed
The right to opt out of fundraising communications
The right to restrict certain types of uses and disclosures of your protected health information
The right to receive a printed copy of this notice

Peter L. Karlsberg, M.D., A Medical Corporation [DBA: Ventura Institute of Dermatologic Arts] 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 also are required to abide by the privacy policies and practices that are outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised, it is our duty to notify you.

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. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records from our reception desk or by contacting Gracie Cervantes. Your request will be reviewed an will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, please send a letter outlining your concerns to:

Practice Administrator
Peter L. Karlsberg, M.D., AMC
1190 S Victoria Ave, Suite 300
Ventura, CA 93003

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.

Contact Person
The name and address of the person you may contact for further information concerning our privacy practices is:

Practice Administrator
Peter L. Karlsberg, M.D., AMC
1190 S Victoria Ave, Suite 300
Ventura, CA 93003
805-677-1600

Effective Date
This notice is effective on or after January 1, 2017.

ACKNOWLEDMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Peter L. Karlsberg, M.D., A Medical Corporation [DBA: Ventura Institute of Dermatologic Arts] reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the "Notice of Privacy Practices" for Peter L. Karlsberg, M.D., A Medical Corporation [DBA: Ventura Institute of Dermatologic Arts].

_____ _____ / _____ / _____

Signature of Patient/Legal Guardian Date

VENTURA INSTITUTE OF DERMATOLOGIC ARTS

COSMETIC QUESTIONNAIRE

Our top priority is always the health of your skin.
Whether your appointment today is for a dermatological concern, a follow-up, a cosmetic service, or a cosmetic consultation, please take a moment to check off any cosmetic concerns you wish to share with us below. This information will help us provide you with some initial guidance about some of the options available to you.

NECK & FACE

- ☐ Discolorations or pigmentations (melasma, brown spots)
- ☐ Enlarged pores
- ☐ Sun damage (uneven tone/texture)
- ☐ Redness or broken capillaries
- ☐ Acne scarring
- ☐ Double chin
- ☐ Sagging skin on face or neck
- ☐ Sagging brow or eyelids
- ☐ Facial lines/creases/wrinkles
  - ☐ eyes/crow's feet
  - ☐ forehead
  - ☐ wrinkles around mouth
  - ☐ other
- ☐ Loss of volume
  - ☐ face
  - ☐ lips
- ☐ I'm not sure, but I'd love to look a few years younger without surgery

HANDS & BODY

- ☐ Leg Veins
- ☐ Bony hands
- ☐ Sun damage (uneven tone/texture)
  - ☐ arms
  - ☐ shoulders or chest
  - ☐ other
- ☐ Excessive underarm sweating
- ☐ Leg Veins
- ☐ Stubborn fat in certain areas of my body: _____
- ☐ Female laxity, dryness or incontinence from aging, pregnancy or childbirth (for example, leaking when you laugh/sneeze)
- ☐ Other: _____

FAMILY MEDICAL HISTORY

Patient Name: _____ ***Date of Birth:*** _____

Reason for Visit: _____

Have you ever had any reactions to local anesthetics? ☐ No ☐ Yes: If yes, please explain:

_____

Do you smoke? Yes _____ No _____ Quit _____ If so, when? _____

If smoking, for how long? _____ How many packs per day? _____

Do you drink alcohol? Yes _____ No _____ Quit _____ Quit date (approx.) _____

If yes, how many drinks per day?_____ Any history of substance or IV drug abuse? Y ☐ N ☐

PATIENT MEDICAL HISTORY

Please check boxes if you have a history of or are currently under treatment for the following conditions:

☐ Arthritis
☐ Artificial Joint/Valve
☐ Bleeding Problems
☐ Blood Thinners
☐ Cancer
☐ Currently Pregnant or Nursing
☐ Glaucoma
☐ Heart Condition
☐ Hepatitis
☐ High Blood Pressure
☐ HIV
☐ Keloids
☐ Kidney Problems
☐ Lung/Breathing Problems
☐ Psychiatric Condition
☐ Radiation Therapy
☐ Skin Cancer
☐ Stroke

☐ Diabetes – If yes, controlled by Insulin _____ Medication _____ Diet _____
☐ Pacemaker – If yes, date placed or revised_____
☐ Organ Transplant, Type & Date_____
☐ Other_____

Other information about your health that we should know about:

_____

_____

_____

_____

SURGICAL HISTORY

List any surgeries below, and any significant complications related to the operations:

Surgery Type	Date	Significant Complications

Review of Systems – Please list any conditions or symptoms you are currently experiencing:

- ☐ Back pain
- ☐ Bladder infection
- ☐ Blood clots
- ☐ Blood in stool
- ☐ Blurry vision
- ☐ Bruise/bleed easily
- ☐ Chest Pain
- ☐ Constipation
- ☐ Cough
- ☐ Diarrhea
- ☐ Difficulty hearing
- ☐ Difficulty urinating
- ☐ Dizziness/fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Joint pain
- ☐ Numbness/tingling
- ☐ Pain/weakness in arms/legs
- ☐ Palpitations
- ☐ Poorly healing cuts
- ☐ Racing heartbeat
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Stomach pain
- ☐ Stroke/CVA/TIA
- ☐ Swelling in legs/feet
- ☐ Vomiting blood
- ☐ Weight loss
- ☐ Wheezing

Other - Please explain below

MEDICATIONS & PHARMACY INFORMATION

Please list your current prescriptions, over-the-counter medications, and herbal supplements below, as well as any you stopped taking in the past year.

DATE STARTED	*MEDICATION*	*DOSAGE*	*FREQUENCY*	*DATE STOPPED*

Do you have any allergies to medications: Yes _____ No _____
If yes, specify: _____

Are you allergic to adhesives, dressings or latex? Yes _____ No _____
If yes, specify: _____

PHARMACY INFORMATION

Our office uses E-Prescribe for most prescription and pharmacies. *Please note that it can take up to 2 hours from the time you leave our office until your prescription is ready to be picked up.*

Patient Name _____ **Patient Date of Birth** _____

Pharmacy Name: _____

Address (or cross streets): _____

FOR OFFICE STAFF: Reviewed by: _____ Date: _____