CONTOUR DERMATOLOGY
& COSMETIC SURGERY CENTER

TIMOTHY M. JOCHEN, MD
BOARD CERTIFIED DERMATOLOGIST

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Title: ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss.

Legal Name *(as it appears on insurance card):* _____
First *Middle* *Last*

Date of Birth: _____ / _____ / _____ Sex: ( ) Male ( ) Female SSN: _____-_____-_____

Race:_____ Ethnicity: _____ Preferred Language: _____

Religion:_____ Occupation: _____ Employer: _____

CONTACT INFORMATION

Mailing Address: _____
Street # *Street Name* *Apt/Unit#*

_____
City *State* *Zip code*

Home #: _____ Work #: _____ Mobile #: _____

What is your preferred method of contact? ( ) Home Phone ( ) Mobile Phone ( ) Text Message ( ) Email

May we email you appointment reminders, newsletters and specials, if so please provide your email:
Email Address: _____

Spouse Name: _____ Phone#:_____ Spouse's Date of Birth: ____/____/_____

Emergency Contact:_____ Phone#:_____ Relation:_____

PARENT OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name: _____ Date of Birth: ____/____/_____ Sex: ( ) M. ( ) F.
First Middle Last

Address: _____

Home #: _____ Work #: _____ Mobile#: _____

REFERRAL SOURCE

How did you hear about our practice? ( ) Physician: _____ ( ) Patient: _____

( ) Webpage: _____ ( ) Commercial ( ) Newspaper ( ) Billboard ( ) Other: _____

PATIENT PRIVACY

Do we have your permission to discuss your medical condition or allow any member of your household to schedule appointments for you?
If Yes, whom: _____ Relationship:_____

If your primary care provider is given we will be sending their office your progress notes unless asked not to:
Primary Care provider: _____

Do we have your permission to:
Leave a message on your answering machine at home? ( ) YES ( ) NO
Leave a message at your place of employment? ( ) YES ( ) NO

Contour Dermatology reminds patients of their appointments by text message, email and by phone call.
If at any time you would like to discontinue one of these communcations you may contact our office to cancel.

Patient Signature: _____ Date: _____

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MEDICAL HISTORY FORM

LABS AND PATHOLOGY

If your insurance requires biopsies or cultures to be sent to specific lab (i.e. Tenet or EMC), please specify: _____
If not, all biopsies & cultures will be processed through our lab choice and *you will be responsible for all charged incurred with them*

ALLERGIES

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list: _____

MEDICATIONS/PRODUCTS

Pharmacy of Choice: _____ Pharmacy Phone #:_____ Cross Streets: _____
Please list all medications you are currently taking (including prescriptions, over-the-counter meds, & vitamins):
Prescriptions: _____
Over-the-Counter: _____

PAST MEDICAL HISTORY

- Do you drink alcohol? ☐ YES ☐ NO If yes, how many per day? _____
- Do you smoke? ☐ YES ☐ NO ☐ FORMER SMOKER
- Have you ever had HIV (AIDS) or Hepatitis? ☐ YES ☐ NO
- Have you ever had skin cancer (Basal Cell Carcinoma, Squamous Cell Carcinoma, and/or Melanoma)? ☐ YES ☐ NO

If yes: Year diagnosed:_____ Location: _____ Type of Skin Cancer:_____
Year diagnosed:_____ Location: _____ Type of Skin Cancer:_____

- Has anyone in your family had a history of skin cancer? ☐ YES ☐ NO Type of Skin Cancer:_____
- List any other diseases or conditions: _____
- List any surgical procedures you have had in the past year:_____

Height:_____ Weight: _____

REVIEW OF SYSTEMS: Check off if you have a history of or currently have any of the listed diseases or conditions:

DERMATOLOGY	History of	Currently
oily skin	☐	☐
dry skin	☐	☐
red or brown spots	☐	☐
fine lines/wrinkles	☐	☐
sun damage	☐	☐

GENERAL	History of	Currently
currently pregnant		☐
currently breast feeding		☐
diabetes	☐	☐
reaction to antibiotics	☐	☐
reaction to bandages	☐	☐
anticoagulant daily	☐	☐

ENDOCRINE	History of	Currently
excessive sweating	☐	☐
heat/cold intolerance	☐	☐

MUSCULOSKELETAL	History of	Currently
arthritis/joint deformity	☐	☐
artificial joints	☐	☐

GASTROENTEROLOGY	History of	Currently
nausea	☐	☐
vomiting	☐	☐
GI problems	☐	☐

PSYCHOLOGY	History of	Currently
depression	☐	☐
suicidal thoughts	☐	☐
mental/physical abuse	☐	☐
mood swings	☐	☐
obsessive-compulsive	☐	☐

BLOOD/LYMPH	History of	Currently
swollen glands	☐	☐
fatigue	☐	☐
varicose veins	☐	☐
easy bruising	☐	☐
bleed easily	☐	☐
blood clots	☐	☐
thyroid problems	☐	☐

CARDIOLOGY	History of	Currently
chest pain	☐	☐
palpitations	☐	☐
leg swelling	☐	☐
heart attack	☐	☐
high blood pressure	☐	☐
pacemaker	☐	☐

NEUROLOGY	History of	Currently
headaches	☐	☐
tingling/numbness	☐	☐
seizures/dizziness	☐	☐

RESPIRATORY	History of	Currently
asthma	☐	☐
chest tightness	☐	☐
cough/wheezing	☐	☐
bronchitis	☐	☐
emphysema	☐	☐

- Do you have a history of any other specific skin diseases/reactions? ☐ YES ☐ NO
  If yes, please describe: _____

NOTICE TO CONSUMERS:
Medical doctors are licensed and regulated by the Medical Board of California (800) 633-2322

Patient Signature: _____ Date: _____

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FINANCIAL POLICY

Welcome to Contour Dermatology and Cosmetic Surgery Center! We are pleased that you have chosen us as your health care provider. Our mission is to provide you with the highest level of professional medical care with the highest degree of patient satisfaction. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care.

INSURANCE Your insurance coverage is a contract between you and your chosen insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not provided, you will be billed and payment in full will be expected within 30 days of receipt of statement. We are currently contracted with most PPO insurance carriers. In the event that we are not aware of a charge that is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

HMO/MANAGED CARE PLANS Contour Dermatology does **NOT** accept HMO insurance plans. Patients with HMO insurance will be considered a "self-pay" patient and will be responsible for payment in full at time of service. We will not attempt to bill your insurance.

MEDICARE We participate in the Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We require all patients to sign an ABN (Advanced Beneficiary Notice) which lists our fees and notifies you of your financial responsibility for certain medical services at every visit.

MEDICARE/MEDI-CAL Our office participates with Medicare, but not Medi-Cal. After billing your insurance, as a professional courtesy, we will write off the amount applied to co-insurance. However, Medi-Medi patients are responsible to pay any amount applied toward their annual Medicare deductible and for services not covered by Medicare. If your deductible has not been met prior to receiving care at our office, you will be responsible for payment at time of treatment.

PATIENT RESPONSIBILITY Patients or their legal representative are ultimately responsible for all charges for services provided including, but not limited to any co-payment, co-insurance, deductible or service not covered by your insurance, bounced check, collection or attorney fees. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. If a deposit is necessary, you will pay an estimate of the expected patient responsibility; when your insurance company notifies us of your patient responsibility, we will either send you a statement for the balance due or issue a refund.

OUTSTANDING BALANCES All outstanding balances are due at time of visit. Upon checking in for any appointment, we will notify you of any outstanding balance. We will request payment for both outstanding balances and any balance related to appointment you are checking in for. Balances can be paid conveniently via the Nextech portal, HealthiPass, in person, or you can keep a credit card on file.

If you have an outstanding balance for more than 45 days, you will be referred to an outside collection agency. Once referred, you must contact the collection agency directly to make payment arrangements.. We will not be able to see you as a patient until your account is resolved with the collection agency. If account remains delinquent, you may be discharged as a patient the practice. Accounts referred to a collection agency, will incur additional fees which include a $25.00 collection fee, addition processing fees, and additional legal fees.

Patient will be subject to a $25.00 processing fee for returned checks.
Patients may be subject to a $10.00 monthly service charge for non-payment of their monthly statement.

In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and you may not be allowed to schedule any additional services unless special arrangements have been made.

Patient Signature: _____ Date: _____

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FINANCIAL POLICY CONTINUED…

LABS AND PATHOLOGY If your insurance requires laboratory specimens to be sent to specific lab it is your responsibility as a subscriber to know the participating labs*, specify your preferred lab*: _____
(If no lab noted we will send specimens to our normal lab and you will be responsible for all charged incurred with them)
Biopsies, Cultures, and specimens cut, shaved, or punched will always be sent to University DermatoPathology Associates (UDPS). Skin pathology reading performed by UDPS and in office slide preparation will incur a separate fee from the initial visit/procedure. Urgent slide preparations are completed by Eisenhower Medical Center and you will be billed by them separately. As a courtesy we will forward your insurance information to these companies for billing purposes.

SKIN CARE AND RETAIL PRODUCTS Contour Dermatology and Cosmetic Surgery Centers Skin Care and Retail Product Return Policy. Returns and/or exchanges of unopened items, with receipt, will be accepted within 14 days of original purchase date. If it is past 14 days from your original purchase date or opened, unfortunately we can't offer you a refund or exchange. *Our return policy does not apply to hydroquinone based products, Renova, Tretinoin, Latisse, or Capillus as these product and devices sales are final*. If you experience an issue with these non-returnable products, please contact the distributor directly. (Our return policy is compliant with California Law Civil Code section 1723)

CANCELLATION AND NO-SHOW POLICY
If you cannot keep your scheduled appointment, please notify our office at least 24 hours of your scheduled appointment to avoid a $50 "no-show" fee. This fee will be your responsibility to pay before scheduling again. Three (3) or more no-shows within any six (6) month period may result in you being discharged from our practice.

REFUND POLICY Refunds cannot be requested after treatment have been performed. There is a 3% processing fee (based on refund amount) that is applied to all non-surgical and surgical procedure refunds requested and deducted from total refund amount.

As a patient of Contour Dermatology, your signature below signifies that you understand this Financial Policy and you are responsible regarding all charges incurred in this office. Furthermore, *by signing this form you as a patient of Contour Dermatology are authorizing your insurance carrier(s), to issue payment check(s) directly to Contour Dermatology for medical services rendered to yourself and/or dependents regardless of your insurance benefits coverage.*

Patient Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Patient Signature: _____ Date: _____

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OPTIONAL COSMETIC QUESTIONNAIRE

Dear Patient,

Our goal is to respond to all of our patient's needs and to provide the highest quality care. In order to provide the information on services and products you desire on the health and appearance of your skin, we invite you to complete the following questionnaire:

PLEASE CHECK ALL CONDITIONS/SYMPTOMS THAT APPLY:

( ) Brown spots on face
( ) Cellulite reduction
( ) Crease near nose/mouth
( ) Dimpled chin
( ) Excess skin above eyes
( ) Frown lines
( ) Gummy smile
( ) Lines around my eyes
( ) Lines between my eyes
( ) Lines on my forehead
( ) Lines under my eyes
( ) Looking tired
( ) Puffy eyes
( ) Red blotchy skin
( ) Sagging neckline
( ) Scarring
( ) Sunk in/hollow eyes
( ) Thin face, no cheeks
( ) Thin lips
( ) Unwanted veins
( ) Wrinkles

PLEASE CHECK ALL SERVICES/PRODUCTS THAT INTEREST YOU:

( ) Blepharoplasty
( ) Botox/Dysport
( ) Chemical Peels
( ) CoolSculpting
( ) Facial Fillers
( ) Facials
( ) Fat Transfer
( ) Hair Transplant Neograft
( ) Hair Transplant Strip Grafting
( ) IPL (Intense Pulse Light)
( ) Laser Hair Removal
( ) Laser Resurfacing
( ) Laser Treatments
( ) Lipodystrophy Treatments
( ) Liposuction
( ) Mini Facelift
( ) Neck/Jowl Tightening
( ) Non-Invasive Fat Reduction
( ) Picoway Laser Technology
( ) Profound
( ) Skin Care Products
( ) Tattoo Removal
( ) Ultherapy
( ) VelaShape III

PLEASE ANSWER THE FOLLOWING QUESTION ON A SCALE OF 1 TO 5 BY CIRCLING THE APPROPRIATE NUMBER:

When looking in the mirror, I believe I look younger, the same as, or older than my true age:

Younger Than		True Age		Older Than
1	2	3	4	5

What are you currently using as your skin care regimen (please list below):

( ) Cleanser/Toner: _____
( ) Sunscreen: _____
( ) Retin-A: _____
( ) Eye Cream: _____
( ) Moisturizer: _____
( ) Night Cream: _____

Patient Signature: _____ Date: _____

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CREDIT CARD ON FILE AGREEMENT AND AUTHORIZATION FORM

At Contour Dermatology and Cosmetic Surgery Center, we now offer a credit card on file agreement as a convenient method of paying for the portion of services you owe after your health plan pays its portion of your claim. Your credit card information is kept confidential and secure, and charges to your card are made only after your health plan makes its payment to us. You have the option of limiting the amount that can be charged as well.

I, the undersigned, authorize and request that Contour Dermatology and Cosmetic Surgery Center charge my credit card for the balance due that my health plan identifies as my financial responsibility. This authorization relates to all charges not covered my by insurance company for services provided to be by Contour Dermatology and Cosmetic Surgery Center. My card will remain securely stored for future use by Contour Dermatology and Cosmetic Surgery Center for payments of balances due from me. This authorization will remain in effect until revoked by me in writing.

CHARGE LIMITS: Balances exceeding $_____ require verbal authorization from me. Charges under this amount require no further authorization.

CARD HOLDER INFORMATION		
NAME:		
BILLING ADDRESS:		
CITY:	STATE:	ZIPCODE:
PHONE:		

CREDIT CARD INFORMATION					
CARD TYPE:	☐ VISA	☐ MASTERCARD	☐ DISCOVER	☐ AMEX	☐OTHER: _____
CARD NUMBER:		**(card will auto save once a payment is processed)**			
EXPIRATION DATE:		CARD IDENTIFICATION NUMBER (CVV2 CODE):			

OFFICE USE ONLY		
Patient Chart Number: _____	☐ Inputted into Nextech	Receptionist: _____

Patient Name (PRINT): _____

Patient Signature: _____ Date: _____