Santa Ana Skin Care Clinic

LEONORA LÓPEZ, MD

Where Beautiful Skin Is Always In

THE INFORMATION REQUESTED ON THIS FORM IS USED TO FILE MEDICAL CLAIMS AND FOR OTHER IMPORTANT MEDICAL DOCUMENTATION. PLEASE PRINT LEGIBLY SO THAT WE MAY ACCURATELY REFLECT YOUR PERSONAL INFORMATION IN ANY TRANSACTION WE MAY NEED TO MAKE ON YOUR BEHALF. THAT INCLUDES CALLING YOUR INSURANCE COMPANY, SENDING REQUISTIONS TO LABS, ETC. THANK YOU

Referring or Primary Care Physician (**FIRST AND LAST NAME)**	**OR:** How did you hear about us?

PATIENT INFORMATION

Patient's last name: First: Middle Int:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name? **THIS IS REQUIRED FOR FILING AN INSURANCE CLAIM***	Preferred Nickname: /	Birth date: / /	Age:	Sex: ☐ M ☐ F

Street address:	Social Security #:
City: State:	ZIP Code:

Occupation:	Employer:	Work Phone #:	Home Phone #:	Cell Phone #:

INSURANCE INFORMATION

PLEASE PROVIDE RECEPTIONIST WITH YOUR INSURACE CARD(S)

Please indicate **primary** insurance company name:			
Subscriber's name ***REQUIRED* This is the person who carries the policy.**	Subscriber's SS#:	D.O.B. ***REQUIRED*** / /	****IN ORDER FOR SASC TO FILE A CLAIM ON YOUR BEHALF, THE INFORMATION ASKED HERE IS REQUIRED. WITHOUT THIS INFO, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE COMPANY, MAKING YOU A SELF PAY PATIENT****
Patient's relationship to the subscriber:	☐ Self ☐ Spouse ☐ Child	☐ Other	
Name of **secondary** insurance (if applicable):	Subscriber's name:	D.O.B.: / /	
Patient's relationship to the subscriber:	☐ Self ☐ Spouse ☐ Child	☐ Other	

Person responsible for bill: ***REQUIRED***	D.O.B. ***REQUIRED*** / /	Address (if different):	Home phone #: ( )

Occupation:	Employer:	Employer address:	Employer phone #: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

Thank you for choosing our office for all of your skin care needs. If at any time you have questions regarding your treatment, please feel free to call the office. Please note that treatment fees are due at time of services, and medical insurance may not cover treatments because they are considered a cosmetic luxury. Also note that results of products and procedures are not guaranteed. Also, all products and services offered through SASC are **non-refundable**.

The above information is true to the best of my knowledge. I authorize my insurance benefits to be directly paid to the physician. I understand that I am financially responsible for any balance. I also authorize Santa Ana Skin Care Clinic or the insurance company to release any information required to process my claim.

_____ _____

Patient / Guardian Signature Date

ALLERGIC TO: _____ _____ _____

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS

_____ DOB:_____ SS#:_____
Name of Patient

I understand that Santa Ana Skin Care Clinic (SASC), from time-to-time, may be requested to disclose my protected health information (PHI) with members of my family, a caregiver or a close friend. Therefore, I authorize the following individuals to access or receive my PHI:

Person's Name: ***Relationship to Patient:***

_____

_____

_____

I authorize SASC to disclose my PHI for the following purposes:

- ☐ Make, change or cancel an appointment for me
- ☐ Obtain test or lab results on my behalf
- ☐ Discuss my current health condition or symptoms
- ☐ Pick-up written prescriptions or pharmaceutical samples on my behalf
- ☐ Other:

_____
_____

I understand that written authorization is required should any of the above named persons request copies of my medical records.

The following individuals are specifically NOT AUTHORIZED to access or receive any of my PHI:

Person's Name: ***Relationship to Patient:***

_____

_____

_____

I understand that if information is requested via telephone, the caller may be asked to identify me by (a) providing my social security number and my date of birth as shown on SASC's records, and (b) the caller's full name shown above. If the request is made in person, the individual may be required to provide proper identification, including a picture ID.

I understand that in order to add or delete designated people from this list, I must notify SASC in writing. I also understand that I may revoke this authorization in its entirety by providing written notification to SASC.

_____ _____
Signature of Patient Date Signature of Personal Representative Date

_____ _____
Printed Name of Patient Printed Name of Personal Representative

_____
Personal Representative's Relation to Patient

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NEW PATIENT MEDICAL HISTORY

CLIENT NAME: _____

1. Please list any drug allergies or sensitivity: _____
_____

2. Have you ever used/are you currently using any of the following? (check all that apply)

___ Retin A ___ Renova ___ Accutane ___ Prescription Acne Medication ___ Steroids

___ Birth Control Pills ___ Depo Shot

3. Please list all prescription and non-prescription medication or herbal supplements that you are currently taking: _____
_____

4. Women: are you pregnant or breast-feeding? ___ Yes ___ No

5. Please list any chronic conditions that are currently treated by your primary care provider:
_____

6. Please list any past hospitalizations or surgeries: _____
_____

7. Have you ever had or been treated for: (check all that apply)

☐ Cancer	☐ Diabetes	☐ Dizzyness / Fainting
☐ Epilepsy	☐ Head Injury	☐ Headaches / Migranes
☐ HIV / AIDS	☐ Melanoma	☐ Nerve Injury
☐ Mental Disease	☐ Multiple Sclerosis	☐ Skin Rash / Disease

8. Do you smoke? ___ No ___ < Pack / day ___ 1 Pack or more / day

9. Have you ever had cold sores or fever blisters? ___ Yes How Often? _____

10. How often do you suntan? _____

_____ I understand that that the information on this form is essential to determine my medical needs and the provision of treatment. I will report any pertinent changes in my medical condition to the office staff as soon as possible. I have read the above questionnaire and acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions I may have made in completion of this form.

_____ I understand that before and after photos may be taken to document the progress of my treatment.

_____ _____

Patient Signature Date Witness Signature Date

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CANCELLATION / RESCHEDULE / NO SHOW POLICY

Failure to keep scheduled appointments is costly to our practice and to other patients. Patients who are not able to keep their scheduled appointments are required to provide timely notice of reschedule or cancellation prior to their appointment time. (See below.) Providing the required notice gives us the opportunity to schedule patients from a wait list so they may be seen sooner.

Any patient who DOES NOT provide required notification of reschedule or cancellation to the staff at SASC is subject to a Cancel / Reschedule / No Show Fee that is not covered by insurance companies.

Due to the nature of services provided, required no-show fees and required notice varies by treatment length. Patients will be informed of fee requirements when appointments are confirmed prior to the scheduled time. A phone number will also be given for providing notification for either cancellation or rescheduling.

• **Office Visits / Consultations**	**1 Business Day**	**$50**
• **Aesthetic Treatments (Non-Fraxel)**	**1 Business Day**	**$50**
• **Fraxel Laser Treatments**	**2 Business Days**	**$150**

Patients FAILING TO PAY the above fee will not be allowed to schedule future appointments and will be sent to collections. Multiple Reschedules, Cancellations, or No Shows may result in dismissal from our practice.

****To Cancel or Reschedule Clinic Appointments, please call (505) 954-4422, EXT. 101****

Signed:_____ **Date:**_____

(Copy to Patient Upon Request)

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FINANCIAL POLICY

Please read our financial policy and indicate your agreement by your signature. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. All patients must complete the appropriate forms before seeing a skin care provider.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
We accept cash, check, Visa, American Express, Discover, Mastercard & Care Credit.

Private pay patients: Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or paid by cash, check, or credit card at the time of services.

Insured patients: If you have insurance, we will help you obtain benefits for covered services. If you have insurance with a company for which we are not providers, we will give you properly completed "super bills" so that you can file your own insurance claims and be reimbursed to the extent of your coverage. We only file claims to insurance companies that we are participating providers for. Filing a claim is not a guarantee of payment. Many of our services are considered to be a cosmetic luxury and are therefore not covered by insurance. You are responsible for the full payment of any denied claims. We provide Botox for cosmetic purposes only, which is NOT covered by insurance.

Insurance: This is a contact between you and your insurance company. In many cases, we are not a party to this contract. We will inform you if we are a party to your contract, and we will handle your claims according to our agreement with your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance usual and customary charges, etc., other than to supply actual information as necessary. In the event that you receive a statement with a balance due after insurance adjustments, you are responsible for timely payment on your account.

Balance due terms: Your signature below indicates your agreement with our terms for any unpaid balance due. Any unpaid balances to customer accounts are subject to being sent to a collection agency after repeated statements are sent to the address provided by the patient. If it becomes necessary to employ an attorney or collection agency to collect an unpaid balance due, those fees will be added to the balance due.

Notice: All products and services offered through Santa Ana Skin Care Clinic are non-refundable.

Responsible Party Signature: _____ Date: _____

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PRIVACY POLICY

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice summarizes how we handle your information, and provides further details of our privacy policies and procedures.

How we may use and disclose your information: We use health information about you for your treatment, to get paid for treatments, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for these reasons. Beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it in writing to stop further uses or disclosures.

Your rights: In most cases you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we will charge you a cost-based fee and these copies will be made within 30 days. You also have the right to request a list of certain types of disclosures of your health information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

Our legal duty: We are required by law to protect the privacy of your health information; provide this notice about our privacy policies; follow the privacy practices that are described in this notice; and seek your acknowledgement of receipt of this notice. We may change our privacy policies at any time.

Privacy complaints: If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

If you have any questions or complaints, please contact:

Office Manager
Santa Ana Skin Care Clinic, PC
2205 Miguel Chavez
Suite E
Santa Fe, NM 87505

(505) 954-4422

Responsible party signature:_____ Date:_____

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PROCEDURE CLAIM REVIEW FORM

Santa Ana Skin Care Clinic would like to make you aware that in the event we should submit a claim to your insurance company for a procedure reviewed here at our clinic, your insurance provider always reserves the right to review and deny any claim they receive. We may be able to find out for you if the procedure does not require a pre-authorization, but these procedures are still subject to review and possible denial. The only time your insurance company is obligated to pay any amount is if they give you a confirmed pre-authorization number which we will keep in your chart. However, if the treatment amount is applied towards a deductible, then you will still be held responsible for payment.

Your signature below indicates you agree to abide by the policy in this form.

I, _____, have read and understand the Insurance Procedure Claim Review Form.