**HALA KOUDSI, M.D., INC.**
**Dermatology & Skin Cosmetic Surgery**
3655 LOMITA BLVD., SUITE 215, TORRANCE, CA 90505-1916
1360 w. 6TH STREET, W. BLDG. #245, SAN PEDRO, CA 90732
(O) 310/ 378-8885 (F) 310/ 378-4248
www.Halakoudsimd.org

# PRIVACY PRACTICES ACKNOWLEDGMENT

## Acknowledgment Form

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

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# PATIENT RECORD OF DISCLOSURES

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.

I wish to be contacted in the following manner (check all the apply):

□ Home Telephone _____
- □ Ok to leave message with detailed information
- □ Ok to leave message with call-back information only

□ Work Telephone
- □ Ok to leave message with detailed information
- □ Ok to leave message with call-back information only

□ Cell Telephone
- □ Ok to leave message with detailed information
- □ Ok to leave message with call-back information only

□ Other _____

_____

_____

Please list any relatives or friends we may release your health information to, should they inquire about it.

_____

_____

_____

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

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## Medical History

Patient Name _____

Are you allergic to any medications? _____ Yes _____ No If yes, Please list:

1. _____ 2. _____

List all medications you are currently taking: _____

_____

_____

When you are exposed to sun do you? _____ Tan only _____ Tan & Burn _____ Burn

Have you ever had skin cancer? _____ Yes _____ No
Has anyone in your family had skin cancer? _____ Yes _____ No
Has anyone in your family had malignant melanoma? _____ Yes _____ No
Do you have history of specific skin disease? _____ Yes _____ No If yes, Please list:
1. _____ 2. _____
Are you experiencing recent or chronic hair losses? _____ Yes _____ No
List any other disease or condition we should know about: _____
List any surgical procedures you have had in the last 6 months: _____
Please answer the following questions:
Do you smoke: _____ Yes _____ No If yes, how much: _____
Are you pregnant: _____ Yes _____ No Due date: _____
Do you have artificial joints: _____ Yes _____ No Do you bleed easily: _____ Yes _____ No

## History of Diseases

Please check if you have now, or have you ever had diseases or conditions of:

| Lung | Vascular | Systemic | |
|---|---|---|---|
| _____ Bronchitis | _____ High Blood Pressure | _____ Diabetes | _____ Convulsions |
| _____ Emphysema | _____ Chest Pain | _____ Kidney | _____ Fainting |
| _____ Asthma | _____ Heart Attack | _____ Bladder | _____ Glaucoma |
| _____ Hay Fever | _____ Heart Murmur | _____ Stomach | _____ Alcohol |
| _____ Chronic Cough | _____ Irregular Heart Beat | _____ Bowel | _____ AIDS |
| _____ Morning Cough | _____ Pacemaker | _____ Hepatitis | _____ Phlebitis |
| _____ Thyroid | | _____ Yellow Skin | |

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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# New Patient Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (  ) _____ Work: (  ) _____ Cell: (  ) _____

Date of Birth: _____ Age: _____ Sex: _____ SS# _____ _____ _____

Referred by: _____

E-mail Address: _____

**Would you like us to send a letter to your referring doctor: _____ Yes _____ No**

## Parent/ Guardian/ Spouse/ Subscriber Information

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (  ) _____ Work: (  ) _____ Cell: (  ) _____

Date of Birth: _____ Age: _____ Sex: _____ SS# _____ _____ _____

Next of Kin: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Insurance Co. _____ HMO _____ Medicare _____ Other _____

*Credit Information is required for check acceptance & special billing arrangements*

Driver License# _____ State of Issue: _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies for our office. Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be verified and you will be asked to pay any deductible, non-covered services and co-payments. Your signature below signifies your understanding and willingness to comply with the policy.

Patient Signature _____ Date _____

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## PHYSICIAN- PATIENT ARBITRATION AGREEMENT

**Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether a medical services rendered were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their rights to have any such dispute in a court of law before a jury, and instead are accepting the use of arbitration.

Each Disputing Party may commence the arbitration process by filing a written demand for arbitration with JAMS and delivering a copy of such demand to all of the other Disputing Parties in accordance with the notice procedures set forth in this paragraph. Unless otherwise agreed by all of the Disputing Parties, the arbitration shall take place in Los Angeles, California, and shall be conducted in accordance with the provisions of JAMS Streamlined Arbitration Rules and Procedures in effect at the time of filing of the demand for arbitration. Each Disputing Party shall cooperate with JAMS in selecting an arbitrator from the JAMS' panel of neutrals and in scheduling the arbitration proceedings. The arbitrator selected shall be neutral and a person familiar with experience in adjudicating matters under the law of the State of California. Each Disputing Party shall participate in the arbitration in good faith and with the goal of completing such arbitration as soon as reasonably practicable and all other costs of arbitration shall be shared equally between the Disputing Parties.

**CLASS ACTION WAIVER:** Notwithstanding any provision to the contrary, any claim under this provision must be brought in the respective party's individual capacity, and not as a plaintiff or class member in the purported class, collective, representative, multiple plaintiff, or similar proceeding ("Class Action"). The parties expressly waive any ability to maintain any Class Action in any forum. The arbitrator shall not have authority to combine or aggregate similar claims or conduct any Class Action nor make an award to any person or entity not a party to the arbitration. Any claim that all or part of this Class Action Waiver is unenforceable, unconscionable, void, or voidable may be determined only by a court of competent jurisdiction and not by an arbitrator.

*THE PARTIES UNDERSTAND THAT THEY OTHERWISE WOULD HAVE HAD A RIGHT TO LITIGATE THROUGH A COURT, TO HAVE A JUDGE OR JURY DECIDE THEIR CASE AND TO BE PARTY TO A CLASS OR REPRESENTATIVE ACTION, HOWEVER, THEY UNDERSTAND AND CHOOSE TO HAVE ANY CLAIMS DECIDED INDIVIDUALLY, THROUGH ARBITRATION*.

The arbitrator shall have no power to modify any of the provisions of this Agreement, to make an award or impose remedy that, in each case is not available to a California court or to make an award or impose a remedy that was not requested by a Disputing Party, and the jurisdiction of the arbitrator is limited accordingly. To the extent permitted by law, the arbitrator shall have the power to order injunctive relief, and shall expeditiously act on any petition for such relief.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Physician or Authorized Representative's Signature | Date | Patient/Representative's Signature | Date |

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## PATIENT RESPONSIBILITY FOR COPAYMENT, DEDUCTIBLE, LATE CANCELLATION AND NO SHOW FEE

**I agree** to be financially responsible for all copayments and my deductible. I assume the responsibility of paying for all services rendered, and for payment of any services which are not covered by my insurance policies.

Due to an increasing number of "no shows" and late cancellation we have found the need to implement this new cancellation policy.

Patient should inform the office no later than twenty-four hours prior to scheduled appointments if they are unable to keep the appointment. If cancellation of an appointment occurs **after** the twenty-four hour time period, or if the patient **"no shows"**
without warning, the patient will be charged a fee according to the length of time allotted for appointment. Regular office visits will be charged a **$25.00 fee**. Mole or Skin Cancer or Cysts or other procedure appointments will be charged a **$75.00 fee.** Moh's Micrographic Surgery (extended skin cancer surgery) will be charged **$200.00**
Due to the cost of the lab technician, who is paid on a per case basis. Cosmetic procedure deposits of approximately **$150.00** may also be forfeited if insufficient notice is given. The amount of cancellation fees for cosmetic procedures will be based on the particular procedure and the time and resources involved. Extenuating circumstances may be considered.

**Forty eight hours** in advance for cancellation Esthetician appointment and a fee of **$50.00** for late cancellation or no show.

If patient has any questions regarding these fees, please ask for further explanation **BEFORE** your next appointment or treatment. This policy allows the doctors to accommodate other patients who are able to take cancelled appointments.

I understand and agree to all of the above terms and conditions.

Patient Name: _____

Patient Signature: _____

Date: _____