NORCAL DERMATOLOGY
MEDICAL | SURGICAL | COSMETIC

Consent for treatment: I give NorCal Dermatology and Cosmetic permission to evaluate and treat my condition(s).

Payment for services: I understand that I am responsible for fees my insurance does not pay toward my claim, including co-payments, deductibles, and services that my insurance considers cosmetic or not medically necessary. I authorize payments be made by my insurance company to NorCal Dermatology and Cosmetic on my behalf.

Release of Information: I authorize release of information to my primary care or referring physician as necessary to provide or coordinate care. I also authorize release of information to my insurance company for claims processing.

Treatment of Minor: I give permission for my child (under **18**) _____ to be treated by NorCal Dermatology and Cosmetic, Khanh Truong, MD or Henry DeGroot, MD. If I am not able to accompany my child to a follow-up appointment, I give permission for my child to be treated in my absence.

Parent/ Guardian _____ DOB _____ Date _____

NOTICE OF PRIVACY PRACTICES CONSENT FORM:

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protested health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be in involved in that treatment directly and indirectly.
- Obtain payment from third party-payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have read and understand your 'Notice of Privacy Practices' containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such 'Notice of Privacy Practices' prior to signing this consent. I understand that this organization has the right to change its 'Notice of Privacy Practices' from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the 'Notice of Privacy Practices'. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out the treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying this consent.

Patient Name _____ DOB _____

Signature _____ Date _____

NorCal Dermatology
196 Wikiup Drive, Santa Rosa, CA 95403 | **Ph** 707.527.9517 | **F** 707.527.9913
www.norcal-dermatology.com

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NAME _____

_____ ****D.O.B.** _____
FIRST MIDDLE LAST

MAILING ADDRESS _____
STREET APT# CITY STATE ZIP

TELEPHONE(_____)_____(_____)_____(_____)_____
HOME CELL WORK E-MAIL

SSN# _____-_____-_____ Gender: _____ Marital Status: **[ ] S [ ] M [ ] D [ ] W**

RACE: [ ] White [ ] Hispanic [ ] Asian [ ] Black or African American
[ ] Native American [ ] Other: _____

LANGUAGE: [ ] English [ ] Spanish
[ ] Other_____

Emergency Contact :_____(_____)_____ **Relationship**: _____
NAME PHONE#

Primary Care Physician: _____ **Referred by**: _____
NAME ADDRESS

PHARMACY: _____
NAME ADDRESS PHONE#

INSURANCE INFORMATION

[ ] Self pay (**NO INSURANCE)**

Primary Insurance _____

Relation to policyholder_____

If patient is **NOT** the policyholder, please provide:

_____
Policyholder's Last name **First**

Policyholder's DOB_____

Policyholder's Address_____
Street Name and number

City, State, Zip_____

Secondary Insurance_____

Relation to policyholder_____

If patient is **NOT** policyholder, please provide:

_____
Policyholder's Last Name **First**

Policyholder's DOB_____

Policyholder's Address_____
Street Name and number

City, State, Zip_____

****TELEPHONE INFORMATION and COMMUNICATIONS RELEASE**

May we leave medical information on your answering machine or cell voicemail? [ ] Yes [ ] No Please specify_____
May we discuss your medical information with family members? [ ] Yes [ ] No Please specify _____
May we communicate with you via email **(given above?)** [ ] Yes [ ] No

SIGNATURE_____ **DATE** _____

TREATMENT OF MINOR: I give permission for my child (***under 18***) _____ to be treated by Khanh Truong, MD or Henry DeGroot, MD. If I am not able to accompany my child to a follow-up appointment, I give permission for my child to be treated in my absence.

Parent/Guardian _____ **DATE** _____
(PRINT) ***(SIGNATURE)***

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NAME_____ **DOB** _____
FIRST MIDDLE LAST

***Reason for your visit today?** _____

How long have you had this problem? _____

Symptoms **(how does it bother you?)**_____

Treatments you have tried? ***(Prescriptions and over the counter)***_____

_____

***CURRENT MEDICATIONS –** include prescriptions and over-the-counter medicines

_____ _____ _____ _____ _____

***ALLERGIES:** to any medications? **[ ] None [ ] IF YES** please list: _____ Reaction:_____ Reaction:_____

***MEDICAL AND SKIN HISTORY:** *Check below if you have or ever had any of the following diseases?*

[ ] Artificial heart valves	[ ] Diabetes mellitus 1	[ ] Liver disease	[ ] Acne	[ ] Hives
[ ] Artificial joints_____	[ ] Diabetes mellitus 2	[ ] Lung disease	[ ] Actinic keratoses	[ ] Itching
[ ] Asthma	[ ] Epilepsy	[ ] Mental/Anxiety disorder	[ ] Alopecia/Hair loss	[ ] Psoriasis
[ ] Bleeding disorder	[ ] Hay fever	[ ] Pacemaker	[ ] Dermatitis	[ ] Rosacea
[ ] Blood clots	[ ] Heart disease	[ ] Seasonal allergies	[ ] Dysplastic mole	[ ] Scabies
[ ] Cancer_____	[ ] Hepatitis A-B-C	[ ] Shingles	[ ] Eczema	[ ] Vitiligo
[ ] Depression	[ ] High Blood Pressure	[ ] Stroke	[ ] Genital Warts	[ ] Warts
[ ] Dementia	[ ] Kidney disease	[ ] Thyroid disease	[ ] Herpes	

PLEASE LIST PAST SURGERIES: _____ _____ _____ _____

SKIN CANCER HISTORY: Have you had **SKIN CANCER?** [ ] Yes [ ] No
If yes, [ ] Melanoma [ ] Basal cell carcinoma [ ] Squamous cell carcinoma [ ] Yes, but don't know type

Locations: _____

FAMILY HISTORY: *Please list any blood relative (**parents, grandparents, siblings, and children**) with a history of*

Skin cancer ***(non-melanoma)*** _____

Melanoma ***(indicate if deceased from melanoma)*** _____

Have you recently had any of the following?

[ ] Allergy symptoms	[ ] Hair loss	[ ] Menstrual problems	[ ] Shortness of breath
[ ] Bleeding problems	[ ] Heat/cold intolerance	[ ] Palpitations	[ ] Swollen lymph node
[ ] Depression	[ ] Joint pain	[ ] Rash	[ ] Weight change

SOCIAL HISTORY
Do you drink alcohol? [ ] Yes [ ] No: If yes, _____drinks/week **DO YOU SMOKE?** [ ] Yes [ ] No: If yes, _____packs/day

OCCUPATION: _____

WOMEN ONLY:
Are you pregnant? [ ] Yes [ ] No Are you breastfeeding? [ ] Yes [ ] No Are you trying to conceive?[ ] Yes [ ] No

***SIGNATURE**_____ **DATE** _____

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Henry DeGroot, MD · Khanh Truong, MD

FINANCIAL AGREEMENT

Thank you for choosing Norcal Dermatology as your specialty provider. We are committed to providing you with quality and affordable health care. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

1. Insurance: We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. As a courtesy, Norcal Dermatology will verify your insurance benefits for you. NOTE: Knowing your insurance benefits is your responsibility. Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit.

2. Patient payment: All copayments are to be paid at the time of service . This arrangement is part of your contract with your insurance company. An amount of 25% of your remaining deductible, up to a maximum of $150 will be due at the time of service, if a copay payment does not apply.

3. Registration: All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card(s) to provide proof of insurance. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have time filing restrictions; if a claim is not received within a specified number of days of the date of service, based on your insurance, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

4. Claims: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract. As a courtesy, Norcal Dermatology will bill your secondary insurance one time for payment. Should we not receive payment or positive process of your claim by your secondary insurance, we will bill you for the balance, and you will be responsible for your secondary payment of your claim.

5. Uninsured patients: We offer a 15-percent discount to our patients who do not have insurance. Please be advised that the discount is only good when the charges are paid at the time of service. If the charges are not paid at the time of service; we will be happy to reschedule your appointment for a later date when you are able to accept our discount and pay in full at the time of service.

6. Credit and collection: If your account is more than 90 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collection, it is the policy of this office to discharge the patient.

7. Missed appointments: Our policy is to charge $50 for missed appointments not canceled within 24 hours. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the Norcal Dermatology financial policy and agree to abide by its guidelines.

x _____ Date_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

CD: updated (12/15MR)

NORCAL DERMATOLOGY
MEDICAL | SURGICAL | COSMETIC

Khanh Truong, MD and Henry DeGroot, MD

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I hereby acknowledge receipt of NorCal Dermatology and Cosmetic's Notice of Privacy Practices.

Name (please print):_____

Signature:_____

Today's Date:_____

Or:

I am a parent or guardian of _____(patient name)
I hereby acknowledge receipt of NorCal Dermatology and Cosmetic's Notice of Privacy Practices with respect to the patient.

Name (please print)_____

Relationship to Patient: • Parent • Legal Guardian • other _____
Please specify

Signature:_____

Today's Date:_____

NORCAL DERMATOLOGY
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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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;

- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 16, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer at 707-527-9517 for more information, in person or in writing.