



Don Mehrabi MD FAAD
Diplomate, American Board of Dermatology

PATIENT QUESTIONNAIRE

Patient Name: Mr. Mrs. Ms. Dr. _____

Date of Birth: _____ Age: _____ Gender: Male Female Other

Address: _____ City: _____ State: _____ Zip: _____

Email Address*: _____ *(Used for appointment reminders and educational articles only)

Home Phone: _____ Mobile: _____ Work: _____

Social Security Number: _____ Driver's License Number: _____

Marital Status: Single Married Divorced Widowed

Occupation: _____ Business Name: _____

Primary Insurance: _____ Secondary Insurance: _____

Subscriber Number: _____ Subscriber Number: _____

Group Number: _____ Group Number: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Mobile: _____ Work: _____

Referral source (Check all that may apply): Google Yahoo! Other Website Yellow Pages

Friend: _____ Physician: _____

Other (please specify): _____

Do you have a **Primary Care Physician (PCP)**? Yes No If Yes, Name: _____

Authorization to Release Information and Assignment of Benefits

Please remember that insurance is considered a method of reimbursing for fees paid to the doctor and is not a substitute for payment. Some companies have fixed allowances for certain procedures, and others pay for a percentage of the charge. It is your responsibility to pay any deductible amounts, co-pays, co-insurance, or any other balance not paid for you by your insurance. I further consent to the use of stored credit card information to automatically pay for remaining patient balances as put forth in the financial policies.

I directly assign all medical and surgical benefits to Don Mehrabi MD APMC and understand that I am financially responsible for all charges not covered by my insurance benefits. I authorize payment to be made to the provider. In the event that the payment is made to the policy holder, I agree to submit payment to this office immediately.

If the account is not paid in full and prior arrangements have not been made, your account(s) may be referred to a collection agency. In the event that your account is referred to such an agency, you will be responsible for all attorney's and/or collection fees.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I have read and understand the information on this form. I certify the information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

*If electronically signed, please write your name between two "/" forward slashes (example: "/Jane Smith/")



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MEDICAL HISTORY FORM

Preferred Language: English Spanish Farsi Other: _____

Do you need a translator? Yes No

Race	
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Black/African-American
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian
<input type="checkbox"/> Native/Indian American	<input type="checkbox"/> Pacific Islander
<input type="checkbox"/> Other: _____	

Ethnicity
<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> Not Hispanic or Latino

Are you allergic to any medications? Yes No

If YES, please list the medication AND the reaction you get: _____

Please list your current medications:

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have a preferred pharmacy? Yes No

If YES, what is the name of your pharmacy? _____

Address: _____ City: _____ State: _____ Phone: _____

Have you had a history of skin cancer, skin cancer surgery, or any other kind of skin surgery? Yes No

If YES, please tell us what kind of skin cancer(s), problem(s), location(s), and the date(s) of surgery:

Basal Cell Carcinoma: _____

Squamous Cell Carcinoma: _____

Melanoma: _____

Do you have a FAMILY history of skin cancer? Yes No

If YES, please tell us what kind:

Basal Cell Carcinoma

Squamous Cell Carcinoma

Melanoma

What medical problems do you have?

Heart Disease

High Cholesterol

Diabetes

Liver Disease

High Blood Pressure

Kidney Disease

Stroke

Tuberculosis

Hepatitis C

HIV / AIDS

Glaucoma / Eye Problems

Depression / Psychiatric

Cancer (please list): _____

Other (please list): _____

What surgeries have you had? None Heart Surgery Pacemaker Abnormal Surgery

Cancer surgery (please list): _____

Cosmetic surgery (please list): _____

Other (please list): _____



MEDICAL HISTORY FORM

What is your **FIRST** problem today? _____

Where is it located? _____

How long have you had this problem? _____

- Is your problem:
- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Episodic (Intermittent) |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Stable | <input type="checkbox"/> Improving |
| | <input type="checkbox"/> Severe |
| | <input type="checkbox"/> Worsening |

What symptoms are you have? (Check all that apply)

- | | | | | |
|----------------------------------|-----------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Burning | <input type="checkbox"/> Crusting | <input type="checkbox"/> Irritated | <input type="checkbox"/> Painful |
| <input type="checkbox"/> Red | <input type="checkbox"/> Oozing | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Itching | <input type="checkbox"/> Swollen |
| <input type="checkbox"/> Growing | <input type="checkbox"/> Scarring | <input type="checkbox"/> Other: _____ | | |

What makes this problem worse? (Check all that apply)

- | | | | | |
|---|---------------------------------------|-------------------------------|--|---------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Pressure | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Food | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Work | <input type="checkbox"/> Menstrual Cycle | |
| <input type="checkbox"/> Medicine(s): _____ | <input type="checkbox"/> Other: _____ | | | |

What makes this problem better? (Check all that apply)

- | | | | | |
|---|---------------------------------------|-------------------------------|--|---------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Pressure | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Food | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Work | <input type="checkbox"/> Menstrual Cycle | |
| <input type="checkbox"/> Medicine(s): _____ | <input type="checkbox"/> Other: _____ | | | |

What treatments have you had for this problem? _____

Comments: _____

What is your **SECOND** problem today? _____

Where is it located? _____

How long have you had this problem? _____

- Is your problem:
- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Episodic (Intermittent) |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Stable | <input type="checkbox"/> Improving |
| | <input type="checkbox"/> Severe |
| | <input type="checkbox"/> Worsening |

What symptoms are you have? (Check all that apply)

- | | | | | |
|----------------------------------|-----------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Burning | <input type="checkbox"/> Crusting | <input type="checkbox"/> Irritated | <input type="checkbox"/> Painful |
| <input type="checkbox"/> Red | <input type="checkbox"/> Oozing | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Itching | <input type="checkbox"/> Swollen |
| <input type="checkbox"/> Growing | <input type="checkbox"/> Scarring | <input type="checkbox"/> Other: _____ | | |

What makes this problem worse? (Check all that apply)

- | | | | | |
|---|---------------------------------------|-------------------------------|--|---------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Pressure | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Food | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Work | <input type="checkbox"/> Menstrual Cycle | |
| <input type="checkbox"/> Medicine(s): _____ | <input type="checkbox"/> Other: _____ | | | |

What makes this problem better? (Check all that apply)

- | | | | | |
|---|---------------------------------------|-------------------------------|--|---------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Pressure | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Food | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Work | <input type="checkbox"/> Menstrual Cycle | |
| <input type="checkbox"/> Medicine(s): _____ | <input type="checkbox"/> Other: _____ | | | |

What treatments have you had for this problem? _____

Comments: _____



MEDICAL HISTORY FORM

What is your **THIRD** problem today? _____

Where is it located? _____

How long have you had this problem? _____

- Is your problem:
- | | | |
|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Episodic (Intermittent) | |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Stable | <input type="checkbox"/> Improving | <input type="checkbox"/> Worsening |

What symptoms are you have? (Check all that apply)

- | | | | | |
|----------------------------------|-----------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Burning | <input type="checkbox"/> Crusting | <input type="checkbox"/> Irritated | <input type="checkbox"/> Painful |
| <input type="checkbox"/> Red | <input type="checkbox"/> Oozing | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Itching | <input type="checkbox"/> Swollen |
| <input type="checkbox"/> Growing | <input type="checkbox"/> Scarring | <input type="checkbox"/> Other: _____ | | |

What makes this problem worse? (Check all that apply)

- | | | | | |
|---|---------------------------------------|-------------------------------|--|---------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Pressure | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Food | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Work | <input type="checkbox"/> Menstrual Cycle | |
| <input type="checkbox"/> Medicine(s): _____ | <input type="checkbox"/> Other: _____ | | | |

What makes this problem better? (Check all that apply)

- | | | | | |
|---|---------------------------------------|-------------------------------|--|---------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Pressure | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Food | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Work | <input type="checkbox"/> Menstrual Cycle | |
| <input type="checkbox"/> Medicine(s): _____ | <input type="checkbox"/> Other: _____ | | | |

What treatments have you had for this problem? _____

Comments: _____

What is your **FOURTH** problem today? _____

Where is it located? _____

How long have you had this problem? _____

- Is your problem:
- | | | |
|-----------------------------------|--|------------------------------------|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Episodic (Intermittent) | |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Stable | <input type="checkbox"/> Improving | <input type="checkbox"/> Worsening |

What symptoms are you have? (Check all that apply)

- | | | | | |
|----------------------------------|-----------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Burning | <input type="checkbox"/> Crusting | <input type="checkbox"/> Irritated | <input type="checkbox"/> Painful |
| <input type="checkbox"/> Red | <input type="checkbox"/> Oozing | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Itching | <input type="checkbox"/> Swollen |
| <input type="checkbox"/> Growing | <input type="checkbox"/> Scarring | <input type="checkbox"/> Other: _____ | | |

What makes this problem worse? (Check all that apply)

- | | | | | |
|---|---------------------------------------|-------------------------------|--|---------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Pressure | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Food | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Work | <input type="checkbox"/> Menstrual Cycle | |
| <input type="checkbox"/> Medicine(s): _____ | <input type="checkbox"/> Other: _____ | | | |

What makes this problem better? (Check all that apply)

- | | | | | |
|---|---------------------------------------|-------------------------------|--|---------------------------------|
| <input type="checkbox"/> Nothing | <input type="checkbox"/> Heat | <input type="checkbox"/> Cold | <input type="checkbox"/> Pressure | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Food | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Work | <input type="checkbox"/> Menstrual Cycle | |
| <input type="checkbox"/> Medicine(s): _____ | <input type="checkbox"/> Other: _____ | | | |

What treatments have you had for this problem? _____

Comments: _____



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PHYSICIAN-PATIENT ARBITRATION

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below.

Effective as of the date of first medical services

Patient's Signature

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy. **NOTICE:** BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.



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FINANCIAL POLICIES

Proof of Insurance: All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, or do not have an up to date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your coverage.

Claim Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. The balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; **we are not party to that contract.**

Not Contracted: If you have a primary insurance that we are NOT contracted with, the total cost of the visit is your responsibility and due at the time of service. If you have a secondary insurance, we will submit ONE claim. If payment is made by either insurance company, you will get the reimbursement from our office in the form of a check. We do not accept secondary assignment of benefits.

Contracted: If you have a primary insurance that we are contracted with, you are responsible for any co-pay, co-insurance or deductible at the time of service. This arrangement is part of **YOUR** contract with **YOUR** insurance company. Failure on our part to collect co-pays and deductibles from patients is considered fraud. Please help us in upholding the law by paying your co-pays. If there is a balance remaining after the primary insurance has paid, we will submit ONE claim to your secondary insurance. You are responsible for payment of any office visits or procedures for which your company denies payment. We do not submit to the secondary insurance company for reimbursement of your co-pay. We do not accept secondary assignment of benefits. You are responsible for the patient's portion that is stated on the primary explanation of benefits.

Tertiary Insurance: We do NOT accept or bill third party insurance policies.

Responsible Party: We realize that many families are in a state of change. Divorced, separated, single parents and blended families are now common. In many of those families, the question of who is financially responsible for the child's care can be complicated. The policy in this office is that the parent/guardian, who is present with the minor requesting treatment, is responsible for payment at the time of service.

Statements: Any unanticipated co-pays or deductibles must be paid upon receipt of the first statement. Any balance outstanding for more than 90 days after the balance has been transferred to you will be sent to collections. Fees associated with the collection process will be added to your balance. Partial payments will not be accepted unless otherwise negotiated. If a balance remains unpaid; you and your immediate family members may also be discharged from the practice.

Forms of Payment: For your convenience, we accept cash, MasterCard, Visa, American Express, Discover and Debit Cards ONLY. No checks accepted. In the event that a check is accepted and returned to us from the bank for any reason whatsoever, a **\$45.00 return fee will be added to your statement.**

Credit Card Authorization: You hereby authorize Don Mehrabi MD APMC to obtain and store your credit card information for payment of patient statement balances. Your credit card will be charged for the remainder of the patient balance after we have received your insurance payment. You have a right to request that we call you before we process this charge. A receipt will be included with your statement and the statement will be marked as PAID IN FULL

Late Fees and Interest Charges: Should an outstanding patient statement balance not be paid in full after 60 days, a \$25.00 late fee will be assessed to your account PLUS a 6.5% finance charge on the balance. A second \$25.00 late charge and 6.5% finance charge will be assessed to your account balance in at 90 days PAST DUE, and this amount will be sent to collections.

Cosmetic Services: Services that your insurance company determines are not medically necessary will require full payment at the time of service. Examples of such services are Botox treatment, microdermabrasion, chemical peels, sclerotherapy and removal of skin tags, normal moles, or benign keratosis.

Missed Appointments: Please call and cancel at least 2 business days before your appointment to help us accommodate other patients. Missed appointments can lead to a \$20.00 service charge and discharge from the practice.

Medical Record Release: A service fee may be assessed for copying medical records. A release of information form must be signed.

Referrals: It is your responsibility to obtain a referral, if one is required, from your primary care physician. Please check with your insurance company to find out if a referral is necessary.

Coverage Change: If your insurance changes, please present your new card before your appointment so we can make the appropriate changes to help you receive your maximum benefits.

Identity Theft: Our system is secured. In the event that there is a breach of our electronic medical records or financial records, you will be notified and a full investigation will be performed. We value your personal information and will take use the highest and full extent of the law to persecute anyone who is involved in accessing, disseminating, or using stored personal information.

Identity theft or personal information breeches will be recognized by either the patient's reporting financial institution or insurance inquiry, or by our routine auditing of our system security. Any breach will be recognized and login information will be analyzed. We will contact the appropriate authorities and report any infraction. In addition, if the breach is electronic, we will shut down our system for a period of time to reinsure its safety and perform diagnostic testing. All persons involved will be prosecuted. Our practice will not be financially liable for breaches of personal information.

Thank you for thoroughly reading and understanding our Financial Policy. Your signature below indicates that you have read, understand and agree to this financial policy.

Signature: _____ Date: _____

*If electronically signed, please write your name between two "/" forward slashes (example: "/Jane Smith/")



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MEDICAL PHOTOGRAPHY

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact any agent of this office.

By signing this form below I confirm that this consent form has been explained to me in terms which I understand.

I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to medical researchers and scientists that regularly use these publications in their professional education. Although these photographs will be used without any identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

For patients 7 to 18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to the use of my images as outlined above.

Signature: _____ Date: _____

*If electronically signed, please write your name between two "/" forward slashes (example: "/Jane Smith/")



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RELEASE OF MEDICAL RECORDS

I consent to medical treatment for myself or for the patient for whom I am the parent or legally authorized representative. I understand that Don Mehrabi MD will share patient health information according to federal and state law for treatment, payment, and operations.

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. Some companies have fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-pays, co-insurance, or any other balance not paid for you by your insurance. I further consent to the use of stored credit card information to automatically pay for remaining patient balances as put forth in the financial policies.

I directly assign all medical and surgical benefits to Don Mehrabi MD APMC and understand that I am financially responsible for all charges not covered by my insurance benefits. I authorize payment to be made to the provider. In the event that the payment is made to the policy holder, I agree to submit payment in full to this office immediately.

If the account is not paid in full and prior arrangements have not been made, your account(s) may be referred to a collection agency. In the event that your account is referred to such an agency, you will be responsible for all attorney and/or collection fees.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I have read and understand the information on this form. I certify the information is true and correct to the best of my knowledge.

Signature: _____

Date: _____

**If electronically signed, please write your name between two "/" forward slashes (example: "/Jane Smith/")*



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HIPAA INFORMATION & CONSENT

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI).

These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services.

www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
10. Identity Theft: Our system is secured. In the event that there is a breach of our electronic medical records or financial records, you will be notified and a full investigation will be performed. We value your personal information and will take and use the highest and full extent of the law to prosecute anyone who is involved in accessing, disseminating, or using stored personal information.

Identity theft or personal information breaches will be recognized by either the patient's reporting, financial institution or insurance inquiry, or by our routine auditing of our system security. Any breach will be recognized and login information will be analyzed. We will contact the appropriate authorities and report any infraction. In addition, if the breach is electronic, we will shut down our system for a period of time to reinsure its safety and perform diagnostic testing. All persons involved will be prosecuted. Our practice will not be financially liable for breaches of personal information.

Signature: _____

Date: _____

*If electronically signed, please write your name between two "/" forward slashes (example: "/Jane Smith/")