ADVANCED DERMATOLOGY AND SKIN SURGERY
GEORGE HSIEH, MD & CYNTHIA YU, NP
4155 Moorpark Ave Ste 3
San Jose, CA 95117
P: 408-217-1905
F: 408-244-1318

14830 Los Gatos Blvd Ste 100
Los Gatos, CA 95032
P: 408-358-1256
F: 408-358-1826

SANJOSESKIN.COM

Appointment Date: _____

Legal Name: _____
First Name (Middle Name) Last Name

Preferred Name: _____ Pronoun: _____ Social Security #: _____

Address: _____**APT/SUITE** #:_____

City:_____ State:_____ Zip:_____

Cell Phone: _____ Work:_____ Home:_____

Email:_____ Marital Status:_____

Patient Date of Birth: _____/_____/_____ Age:_____ Gender:_____
Month / Day / Year

INSURANCE INFORMATION	
PRIMARY INSURANCE	**SECONDARY INSURANCE**
Primary Insurance: _____ Group: _____ Insured's Name_____ Insured's DOB: _____ Sex: _____Female / Male_____	Primary Insurance: _____ Group: _____ Insured's Name_____ Insured's DOB: _____ Sex: _____Female / Male_____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone Number: _____

Name of Parent or Guardian if patient is a Minor: _____

Who may we thank for referring you?

Family: _____ Friend: _____ Ins. Website: _____

Phone Book: _____ Newspaper: _____Other: _____

Referring Physicians Name:_____

Referring Physicians Phone number:_____

Referring Physicians address:_____

PATIENT MEDICAL HISTORY

Advanced Dermatology & Skin Surgery
George Hsieh, MD, FAAD

Name:

Date:

Drug Allergies

MEDICAL HISTORY ☐ None ☐ Yes (check all that apply)

☐ Cataracts	☐ Cancer	☐ Osteoarthritis	☐ Osteoporosis
☐ Glaucoma	☐ Elevated cholesterol	☐ Rheumatoid Arthritis	☐ Kidney Disease
☐ Hay Fever	☐ Elevated triglycerides	☐ Diabetes	☐ Thyroid Disease
☐ Tuberculosis	☐ High Blood Pressure	☐ Anemia	☐ HIV+/AIDS
☐ Ulcerative Colitis	☐ Heart Disease	☐ Peptic Ulcer	☐ Nail Disorders
☐ Asthma	☐ Liver Disease	☐ Acid Reflux (GERD)	☐ Stroke/TIA
☐ Organ Transplant	☐ Emphysema	☐ Irritable Bowel Syndrome	☐ Epilepsy
☐ Depression	☐ Anxiety	☐ ADD/ADHD	☐
☐ Pregnant	☐ Due Date	☐ Trying to get Pregnant	

REVIEW OF SYSTEMS ☐ None apply ☐ Yes (check all that apply)

☐ Tendency to scar	☐ Daily aspirin/anticoagulant	☐ Difficulty with oral antibiotics
☐ Joint Replacement	☐ Immunosuppressed	☐ Allergic to antibiotic ointments
☐ Pacemaker/Defib	☐ Mitral Valve Prolapse	☐ Allergic to bandages and/or tape
☐ Other _____		☐ **Organ Transplant:** _____

CURRENT MEDICATIONS ☐ None ☐ Yes (list all) ☐ See Attached List

PERSONAL HISTORY Skin Cancer: ☐ None ☐ Yes (list all)

☐ Basal cell carcinoma	When?	_____	Body Location?	_____
☐ Squamous cell carcinoma	When?	_____	Body Location?	_____
☐ Melanoma	When?	_____	Body Location?	_____

Do you have other Skin Problems ☐None ☐Yes (list all) _____

FAMILY HISTORY OF SKIN CANCERS ☐ No/Unknown ☐ Yes (list all)

☐ Basal or Squamous cell carcinoma	Relationship?	_____
☐ Melanoma	Relationship?	_____
☐ Unknown type of Skin Cancer	Relationship?	_____

☐ **Are there other skin problems in the family** ☐None ☐Yes (list all) _____

PERSONAL SOCIAL HISTORY ☐ None ☐ Yes (Check all that apply)

☐Smoke ☐Drink Alcohol ☐Special Diet ☐Regular Exercise ☐Tanning Bed ☐Moderate to severe sun exposure

OCCUPATION _____

PHARMACY Name _____ Phone Number _____
Location _____ City _____

FOR OFFICE USE

Init/Date – First Visit:	Init/Date – Follow Up Visits requiring modifications:				

Advanced Dermatology & Skin Surgery

Office Financial Policy

Dear Patient or Guardian:

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare:

We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

a. The annual deductibles
b. Copayments
c. Charges for noncovered or cosmetic services

If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Non-Medicare/Commercial Plans:

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans.

Your Responsibility

Insurance coverage is not a guarantee of payment. There are several reasons why your insurance may not pay for your visit. These include:

a. You have not met your annual deductible. Many policies have a separate, higher deductible for in-office/outpatient surgical procedures.
b. You have not received the proper referral or preauthorization for this visit or procedure.
c. The services or procedures are not covered by your insurance. This varies greatly among insurance companies and plans. Examples might include certain types of cosmetic treatments, like chemical peels, Botox and removal of certain non-cancerous growths such as skin tags.
d. We are currently not contracted with your insurance carrier.

We will inform you when we know a treatment or procedure will not be covered by your insurance but many times it is not possible for us to know with certainty. Often, insurance companies will not make a determination until they have received the claim. Office visit co-pays in most cases cover only the office visit itself, and services including but not limited to injections, biopsies, excisions, or wart treatment, may be applied to the annual deductible of your plan. Ultimately, it is your responsibility to know what provisions, restrictions and requirements are included or excluded in your specific health insurance policy. If there is any uncertainty about coverage, we will be happy to provide you with an estimate of our fees before treatment begins.

Referrals
If your insurance requires that you have a referral to see us, it is the responsibility of either yourself or your primary care physician to deliver that referral to this office prior to or at the time of your visit. A referral is not a guarantee of payment by your insurance company.

Laboratory/Pathology Services
It is the policy of this office to send all surgically removed specimens for expert consultation regardless of the pre-biopsy or pre-surgery diagnosis. You are responsible for any charges not covered by your health insurance. These charges will be billed to you separately and are not included in the charges from our office. The laboratory will bill your insurance as long as you have provided us with accurate information.

Payment at the Time of Service and Notice Regarding Insurance
Any co-payments, co-insurance or deductibles must be paid at the time of service. Payment may be made by cash, check or credit card (visa or master card). If both covered and non-covered services are performed at the same visit, you must pay your co-payment as well as the non-covered service. Returned checks will incur a $25.00 administrative fee.

If you do not have active Medical Insurance, payment will be required in full at the time of your visit.

If we are filing insurance for your visit, we must have complete information, and any required referral information at the time of your visit. If you cannot provide us with this information, we will not be able to file your claim and payment in full will be required at the time of your visit.

If we are unable to determine that services provided will be charged against your Plan Deductible, such as surgical or office procedures, that amount may be due at the time of your visit, in addition to any Co-Pay or Co-Insurance.

It is our pleasure to serve you and we welcome you to our practice. Thank you for understanding these financial policies.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____
Printed Name of Patient

_____ ____/____/____
Signature of Patient or Legal Guardian **Date**

Advanced Dermatology & Skin Surgery

Missed Appointment Policy

We value your time. It is our pledge to meet with you for your appointment in a timely manner as is possible and we expect for you to make all reasonable efforts to attend your appointments and to be on time.

When you schedule your appointment, you have reserved this time in our schedule and we have placed it aside to meet with you. If you must cancel or change your appointment, we require that you contact our office at 408-217-1905 for San Jose office or 408-358-1256 for Los Gatos office at least 24 hours in advance. This will allow our staff to contact patients on our waiting list and to offer them this appointment time.

If you do not keep your appointment and have not called to cancel or reschedule within the allotted time limits, you will be charged $50.00 for missed office visit appointments and $100.00 for missed surgery appointments.

The only exceptions to this policy are appointments missed due to last minute illness, or an emergency outside of your control. You should note that insurance companies do not reimburse members for such charges.

You will be billed directly for missed appointment. Payments for missed appointments are due on or before your next scheduled appointment. If you have not paid in advance, you should be prepared to pay this fee at the time you check in for your next appointment.

As courtesy, our staff will try and call you the working day before your next appointment to help remind you to attend. However, this is a courtesy call only. You are still responsible for remembering your appointment and attending. Not receiving this call or receiving it after the 24 hour time limit does not excuse you of this responsibility.

Thank you for taking time to review our missed appointment policy.

_____

Printed Name of Patient

_____ ____/____/____

Signature of Patient or Legal Guardian **Date**

Advanced Dermatology & Skin Surgery

Authorization for Examination and Treatment

Name of Patient: _____

I have the legal authority to authorize the examination and treatment of the above patient by George C. Hsieh, M.D. and his associates, as he deems necessary for the treatment of my (his/her) skin condition. I understand the examination and treatment may include laboratory tests, medications, and other diagnostic procedures and tests normally provided in a dermatology clinic. If any treatments or procedures are required, it will be explained to me by the physician or physician's designee.

Signature:_____ Relationship to Patient:_____ Date:_____

Authorization to Release Information: I hereby authorize George C. Hsieh, M.D. to release to my insurance carrier any information regarding my illness and/or injury including laboratory reports, x-rays, and diagnosis which required to process the claim.

Assignment of Insurance Benefits: I hereby authorize the above insurance carrier to pay directly to George C. Hsieh, M.D. any benefits that accrue to me under the above indicated insurance and/or disability benefits for services rendered.

Financial Responsibility for Those Who Have Insurance: I understand that I am financially responsible for any amounts not covered by my insurance, including co-payments and deductibles and that there will a $25.00 charge for any returned checks. I understand that any balance unpaid by insurance will be billed to me and if this balance is not paid within two months, there will be a $25.00 charge added and it will be sent to collections.

For Those Without Insurance: I understand that I am financially responsible for all services incidental to treatment. I understand that payment is expected at the time of service. If other payment arrangements are made, I understand that any amount billed to me must be paid within 30 days and is subject to a $25.00 service charge for every month that it is unpaid.

A photocopy of this form shall be as valid as original.

Patient/Guardian Signature: _____ Date: _____

Advanced Dermatology & Skin Surgery

NOTIFICATION/ACKNOWLEDGEMENTS

Patient Name: _____

Date of Birth:_____

Contact Information

Advanced Dermatology & Skin Surgery, Inc. would like to contact you for various reasons, including Personal Health Information (PHI) related to Appointment Reminders, Appointment Recalls and Notification of Test Results.

_____ Yes, you may leave PHI at the Primary Telephone Number and at the address I provided.

_____ No, do no leave PHI.

Notice of Privacy Practices Written Acknowledgement Form

I acknowledge that Advanced Dermatology & Skin Surgery, Inc. has made the Notice of Privacy Practices available. Do you give our office permission to discuss your private health information with other parties?

_____ Yes _____ No If yes, please provide the names.

_____ Spouse (List Name): _____

_____ Parent (List Name): _____

_____ Other (List Name): _____

Patient/Guardian Signature: _____ **Date**: _____

Advanced Dermatology & Skin Surgery

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 review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information and we describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

The following paragraphs describe different ways that we use and disclose your protected health information as provided by law. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally, we may from time to time disclose your health information to another physician who we have requested to be involved in your care. *For example* - we would disclose your health information to a specialist to whom we have referred you for a diagnosis or opinion to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For example* - we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will use and disclose your protected health information to support the business activities of our practice. *For example* - we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff' s performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting, or transcription services for our practice.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We may use and disclose your protected health information to contact you as a reminder about scheduled appointments or treatment.

Treatment or Service Alternatives. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or other services that may be of interest to you.

Others Involved in Your Care. When necessary, we will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify who is involved in your medical care or payment for care.

Research. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law. You may request an accounting of such disclosures at any time (refer to An Accounting of Disclosures paragraph on the next page for details).

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness in accordance with state law.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights:

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other records we use for making medical decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request as permitted by state law.

If you wish to inspect or copy your medical information, you must submit your request in writing, bearing your signature, to our Privacy Officer at Advanced Dermatology and Skin Surgery, 4155 Moorpark Ave., San Jose, CA 95117. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request. If any or all of the information is stored off-site, we are allowed up to 60 days to provide the requested information, but must inform you of this delay.

Request Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing or does not include a reason to support the request. By law, we may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set maintained by this practice; or
- it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* -you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for that care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation), nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the costs of providing the subsequent list as permitted by state law. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. *For example* -you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our practice, or directly to the Secretary of Health and Human Services.

To file a complaint with our practice, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to ATTN: Privacy Officer, Advanced Dermatology and Skin Surgery, 4155 Moorpark Ave, Ste 3, San Jose, CA 95117. You should know that there could be no retaliation for your filing a complaint.

Uses or Disclosures Not Covered:

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. *For* example - if you request that we transfer your medical records to another provider, we will ask you to sign an authorization for us to do so. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

For More Information:

If you have questions or would like additional information, you may contact our practice manager at (408) 217-1905.

Effective Date: May 1, 2011