

New Patient Registration Information

Wilshire Aesthetics

Name _____ Date of Birth _____ male/female

Address _____
street city state zip

Phone #'s _____
home cell work

SSN _____ email _____

Employer _____ Occupation _____

Primary Physician _____ Physician's Phone _____

Address _____
street city state zip

Emer. Contact _____ Phone _____ Relationship _____

How did you hear about us? *please check the primary influence below*

- My friend/relative _____ suggested you.
- My primary physician referred me to you.
- I found you in the search results of Google Yahoo!
- I found you listed on my Health Provider's website printed catalogue
- I saw your ad in Frontiers IN Magazine LA

Name - printed

Signature

Date

Patient Demand for Cosmetic Procedures

Wilshire Aesthetics

Dear Patient;

I want to thank you for coming to my office today and for entrusting me with your dermatology care.

I am currently assessing which cosmetic services are of most interest to my patients. So, if you don't mind, could you please take a few moments to complete the following three questions? The results are completely confidential.

1. I have an interest in the following services. *Please check all that apply.*

- softening or reducing **wrinkles** *check all that apply*
 forehead frown lines smile lines crow's feet lip lines

- improving the appearance of **facial skin** by reducing: *check all that apply*
 brown sun/age spots red discoloration due to visible blood vessels

- deep pore cleansing of skin to **unclog pores** and decrease **pore size**

- eliminating **growths** on the face and/or body *check all that apply*
 skin tags moles lipomas

- eliminating **sagging neck** skin, aka "gobble neck"

- restore **lost volume** to the: *check all that apply*
 cheeks temples lips buttocks

- liposuction to eliminate localized **fat deposits** *check all that apply*
 belly love handles chest thighs hips neck

- get expert advice on the best **skin care products** for your skin

- hair removal**

2. When looking at my face in the mirror, I believe that I look younger, the same as, or older than my true age.

younger than true age older than
1 2 3 4 5

3. When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

not concerned somewhat concerned very concerned
1 2 3 4 5

I would like the opportunity to discuss my answers. *yes* *no*

Name

Date

Payment Policy for PPO, In Network Services

Wilshire Aesthetics

Cosmetic Services: Payment is due at time of service.

Medical Services: Wilshire Aesthetics (WA) is a PPO, in-network, provider for the following Insurance Providers (IP):

- Aetna - Great West - Health Net - Blue Shield
- Cigna - Medicare - Pacificare - United Healthcare
- MultiPlan Network

We do not accept any HMO or MediCal insurance plans.

As a courtesy to you, we will process and bill your Insurance Provider (IP) for the services we provided. In order to bill your IP, we will need *all* of the following:

1. Current/valid *Patient Registration Form* including Social Security Number
2. Photocopy of your Valid Driver's License or State Issued ID Card
3. Photocopy of your most recent Insurance Card
4. *Credit Card Authorization Form* and Photocopy of your Credit Card
5. Signed copy of this form

Once WA receives a response from your IP, we will not send you a statement for balances that your IP does not cover. The outstanding balance is located on the Explanation of Benefits (EOB) which is sent to you by your IP.

In the event that you or your IP requests your medical records, a fee of \$35 will be added to your bill for retrieving, copying, and mailing your records.

I understand that:

- I am responsible for paying any applicable "co-pays".
- if I have not met my deductible, then I am responsible for paying for my deductible. I authorize WA to charge the deductible to my credit/debit card on file.
- if my IP does not pay for my procedure because it considers the procedure "cosmetic", then I am responsible for paying the outstanding balance. I authorize WA to charge the outstanding balance to my credit/debit card on file.
- when WA charges my card on file, WA will send me a copy of the charge receipt.
- outstanding balances not paid within these terms will incur a 1.5% per month late charge.

Name - printed

Signature

Date

Wilshire Aesthetics does not do battle with your Insurance Provider in order to obtain reimbursement. We suggest that you stay in close communication with your IP. Your involvement with the process may expedite the accurate processing of your bill.

Payment Options for Services
When Wilshire Aesthetics is not a Provider in your Health Plan's Network

Wilshire Aesthetics

Cosmetic Services: Payment is due at time of service.

Medical Services: We offer two payment options. *please initial one option below*

____ **Option 1 : don't bill my Insurance Provider (IP) for me**

I will pay for my medical services on the day I receive them.

____ **Option 2 : bill my Insurance Provider (IP) for me**

I understand that:

- my IP has 45 days to respond to Wilshire Aesthetics (WA).
- If my IP pays the full amount of my bill, then I owe WA nothing.
- If my IP pays for only a portion of my bill, then I am responsible for paying the outstanding balance. I authorize WA to charge the outstanding balance to my credit/debit card on file.
- If my IP does not respond to WA within 45 days, then I am responsible for paying the outstanding balance. I authorize WA to charge the outstanding balance to my credit/debit card on file.
- when WA charges my card on file, WA will send me a copy of the charge receipt.
- outstanding balances not paid within these terms will incur a 1.5% per month late charge.

As a courtesy to you, we will process and bill your IP for the services we provided. In order to bill your IP, we will need *all* of the following:

1. Current/valid *Patient Registration Form* including Social Security Number
2. Photocopy of your Valid Driver's License or State Issued ID Card
3. Photocopy of your most recent Insurance Card
4. *Credit Card Authorization Form* and Photocopy of your Credit Card
5. Signed copy of this form

In the event that your IP requests your medical records, a fee of \$35 will be added to your bill for retrieving, copying, and mailing your records.

Name - printed

Signature

Date

Wilshire Aesthetics does not do battle with your Insurance Provider in order to obtain reimbursement. We suggest that you stay in close communication with your IP. Your involvement with the process may expedite the timely processing of your bill.

Cancellation – “No Show” Agreement

Wilshire Aesthetics

Overview When you schedule an appointment at Wilshire Aesthetics, we block out time specifically for you. We reserve staff, exams rooms, equipment, and an appropriate amount of time so that we can provide you with the best service possible. The amount of resource we reserve depends on the type of appointment you make.

We realize that sometimes circumstances require you to cancel or reschedule an appointment. We ask that you provide us with at least 48 hours notice when you cancel or reschedule an appointment.

Our Promise to You If you call us at least 48 hours prior to your appointment, then we will not charge you a cancellation fee.

Your Promise to Us **I promise** to call Wilshire Aesthetics if I cannot keep my appointment. If I notify Wilshire Aesthetics more than 48 hours ahead of time, I will not be charged for my cancellation. If I call Wilshire Aesthetics less than 48 hours, I authorize Wilshire Aesthetics to charge my credit card on file. I understand that the charge will be between \$75 and \$150 depending upon the type of appointment I had made.

Name – printed

Signature

Date

Please note: 48 hours does not include weekend hours

Credit Card / Debit Card Authorization

Wilshire Aesthetics

Card Information

Card Number: _____ Exp. Date _____ V Code _____

Card Holder Name _____ Phone Number _____

Billing Address _____
Street City State Zip

Our Commitment to You

- We keep your card Information **locked** safely away.
- Your information is always kept **confidential** and **private**.
- We **do not share** your card information with anyone.
- We only charge your card for services provided to you or to those you designate below.
- You will **always** receive a **receipt** when we charge your card.

Patient Authorization

I authorize Wilshire Aesthetics to charge my card for services provided to me and the following patients:

Patient 1 _____

Patient 2 _____

Patient 3 _____

I understand that I will incur an additional \$25 service fee if my card transaction/charge is denied.

Name - printed

Signature

Date



PATIENT'S BILL OF RIGHTS

The patient has the right to:

1. Considerate and respectful care.
2. Knowledge of the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of the other physicians and non-physicians who will see the patient.
3. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
4. Participate actively in any decisions regarding medical care. To the extent permitted by the law, this includes the right to refuse treatment.
5. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
6. Confidential treatment of all communications and records pertaining to his/her care.
7. Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing the care.
8. Be advised if the physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.
9. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
10. Have complaints forwarded to administrative personnel for appropriate response.
11. Know that all the clinic/office personnel will observe these patient's rights.



SIGNATURE _____

DATE _____

PATIENT'S RESPONSIBILITIES

The care that a patient receives depends partially on the patient. In addition to these rights, a patient has certain responsibilities.

1. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health
2. The patient is responsible for making in known whether he/she clearly comprehends the course of medical treatment and what is expected of him/her.
3. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of the nurse or other health professionals as they carry out the physician's orders.
4. The patient is responsible for keeping appointments and for notifying the office when he/she is unable to.
5. The patient is responsible for his/her actions should he/she refuse treatment or choose not to follow his/her physician's orders.
6. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled.
7. The patient is responsible for being considerate of the rights of the other patients and office personnel.



SIGNATURE _____

DATE _____

PRINTED NAME _____



5757 Wilshire Boulevard, Promenade 2
Los Angeles, CA 90036
(323) 936-1245
(323) 936-0887 Fax

Full Body Skin Examination

Skin cancer is the most common malignancy in the United States. The Skin Cancer Foundation recommends yearly clinical full body skin examinations to check for suspicious skin lesions. Because skin cancer can appear on any part of the body (sun exposed and non-sun exposed areas alike), be prepared for a “true” full body exam in which the entire body is scanned. This includes fingers, toes, and areas normally covered by undergarments. If we feel there is a lesion suspicious for cancer, a biopsy may need to be performed. To help prepare for your exam, we ask you to circle any concerning lesions with a pen before you arrive to your appointment. These lesions typically are ones that are changing in size, color, texture or that bleed.

(check one)

Yes, I would like to schedule an appointment with the Dermatology Physician Assistant for a full body skin examination at my next visit.

No thank you. I do not wish for a full body skin examination at this time.

Printed Name

Signature

Date



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.**

USES AND DISCLOSURES

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Wilshire Aesthetics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- ◆ the right to request restrictions on the use and disclosure of your protected health information
- ◆ the right to receive confidential communications concerning your medical condition and treatment
- ◆ the right to inspect and copy your protected health information
- ◆ the right to amend or submit corrections to your protected health information
- ◆ the right to receive an accounting of how and to whom your protected health information has been disclosed
- ◆ the right to receive a printed copy of this notice