rebeccafitzgeraldMD
dermatology

323.464.8046

PATIENT INFORMATION

as of _______________mm/dd/yy

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ______________________________
First Middle Last

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Confirmation by Text Message: ☐No ☐ Yes
If yes, text will be sent to mobile number provided.

E-mail ______________________________

Would you like to receive our monthly e- newsletter?
☐ No ☐ Yes

Referred by: ______________________________

Age ________ Birthdate ____________ SS# ____________ Sex ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: ____________ ☐ Other: ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ________ Is it okay to call you at work? ☐ Yes ☐ No

Address ______________________________
Street & Suite # City State Zip

Emergency Contact ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Address ______________________________
Street & Apt # City State Zip

Primary Health Insurance Company ______________________________

Mem ID# ____________ Group# ____________ Ins. Phone ____________

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes $ ____________

Insured: Name ____________ DOB ____________ Employer ____________

Secondary Health Insurance Company ______________________________

Mem ID # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ ____________

Insured: Name ____________ DOB ____________ Employer ____________

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Fitzgerald and her associates to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that this contract is between Rebecca Fitzgerald, MD, Inc. (RFMD) and myself.

I acknowledge and understand that RFMD reserves the right to charge a fee for appointments cancelled or rescheduled without a 24 hour advanced notice. ***Initial*** ________

Signature ______________________________ **Date** ____________

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HEALTH HISTORY

as of _______________ mm/dd/yy

(Please Print Legibly & Fill In or Correct All Fields)

Continued from page 1

Patient's Name ____

First Middle Last

Age ________ Birthdate ________________ Height __________ Weight __________ Gender ☐ Female ☐ Male

Purpose of Visit: ____

History of Present Illness: ____

Previous Surgeries with Dates: *(Including cosmetic)*

____

____

____

Health Problems Past & Present: *(circle any that apply)*

☐ Diabetes ☐ High Blood Pressure ☐Hives/Eczema ☐ Heart Problems

☐ Easy Bruising ☐ Lung/Breathing Problems ☐Tuberculosis ☐ Bleeding/Clotting Problems

☐ Cancer ☐ Psychiatric / Depression ☐Peptic Ulcer ☐ Liver ☐Kidney ☐Anemia

☐ Other: ____

Do you smoke? ☐ No ☐ Yes How many packs a day? __________________

Medications: *(include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)*

____

____

____

Drug or Latex Allergies: *(please indicate if none)*

____

____

Primary Physician ______________________________ Phone ____________________

First and Last Name

Date of Last Physical: ________________________

The above information is accurate and complete to the best of my knowledge.

Signature ____ **Date** ____________________

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PATIENT ACKNOWLEDGMENT OF
HIPAA NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

____ ________________________

Signature of Patient Date

MEDICARE AUTHORIZATION (To be filled by Medicare Patients only):

I request that payment of authorized Medicare benefits be made either to me or on behalf to **Rebecca Fitzgerald, M.D**. for any services furnished tome by that physician. I authorize any holder of medical information about me to release to the **Rebecca Fitzgerald, M.D.** and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurance or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ________________________

Signature of Patient Date

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NOTICE OF PRIVACY PRACTICES

All Patients will be asked to sign acknowledging the receipt of this Notice of Privacy Practices from us. This notice describes how your medical information may be used and disclosed by us and how you may gain access to your medical information. Please review the following carefully so that you may understand your rights as a patient under the federal Health Insurance Portability and Accountability Act (HIPAA).

Our Responsibilities to You Under HIPAA:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you provide written consent. Once consented, you may still change your mind at any time. Should you wish to do so you must inform us with written consent.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Your Rights as a Patient Under HIPAA – You May:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have on file. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will inform you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you requested we make) We will provide a yearly disclosure for free but will charge a reasonable, cost-based fee if you ask for a secondary copy within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting our office.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

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Financial Policy

Please read and sign. Let us know if you have any questions. Thank you

Cosmetic

- Payment is due in full at the time of service.
- We accept Cash/Check/Visa/MasterCard/American Express/CareCredit.
- Under no circumstances will cosmetic procedures be billed to your insurance plan.

Appointment Policy

- If you need to reschedule or cancel an appointment, we require notification 24 hours prior to your appointment.
- If less than 24 hour notice or fail to no show, you will be subject to a last minute/ or no show cancellation fee. (Cosmetic no show/last minute cancellation fee $250, Medical no show/last minute cancellation fee $50)
- This policy applies to all providers.

Laboratory

- Path MD/UCLA will bill you and/or your insurance plan directly for laboratory services rendered such as cultures, biopsy specimens, etc.

Medical/Insurance

- We are contractually obligated to collect co-payments, co-insurance, and deductibles that are required by your plan at time of service.
- As a courtesy, we will submit insurance claims directly to the PPO/Medicare insurance carrier.
- It is your responsibility to be aware of any restrictions, limitations, and requirements outlined by your insurance policy. As well, as updating our office when your insurance has changed.

Credit Card on File

- In an effort to streamline and improve our billing process we do require that all of our medical patients have a credit card on file with us which we utilize to charge any balances remaining after your insurance company pays its portion of the bill. All balances under $100 will be automatically processed . Your credit card information is not kept on file in this office. It is stored securely offsite in a PCI compliant gateway maintained by our credit card processing company. It is not accessible or visible to anyone after it is entered into this system. If the remaining balance is more than $100, we will contact you before charging your credit card.

Your signature below:

Authorizes assignment of benefits to be made to Rebecca Fitzgerald MD, Inc
Accept full financial responsibility for all expenses incurred and agree that you are responsible for any portions not paid by your insurance
Authorize the release of any information required to obtain payment of medical benefits.
You have read and understand this policy in its entirety and that your questions have been adequately answered.

____________________________	________________________________	________________
Print	Signature	Date

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Please Note: Your credit card information is not kept on file in this office. It is stored securely offsite in a PCI compliant gateway maintained by our credit card processing company. It is not accessible or visible to anyone after it is entered into this system. We will shred this document as soon as it is transferred to this system.

Until further notice, I hereby authorize Rebecca Fitzgerald MD, Inc to charge my credit card for any or all of the following:

- The patient responsible balance on my account after my insurance company has paid their portion. I understand that I will receive a courtesy call one day prior to charging my card for any amount that exceeds $100.
- Per Financial Policy Consent, any late cancellation and/or no show fee incurred.
- Cosmetic dermatology services rendered on the day of service
- Product Purchases---purchased in the office or by phone

Type of Credit Card: _________ Last Four Digits of CC #:________

____________________ X __________________________________

Date Signature of Cardholder

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Physician-Patient Arbitration Agreement

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 right 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 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 part'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 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 92) 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 or Patient Representative's Initials

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.

By: ____
Physician's or Authorized Representative's Signature/ Date

Rebecca Fitzgerald, M.D.
____
Print or Stamp Name of Physician, Medical Group, or Association Name

By:____
Patient's or Patient Representative's Signature/ Date

By:____
Print Patient's Name

____
(If Representative, Print name and Relationship to Patient)