TLC DERMATOLOGY MEDICAL CENTER INC.

375 Smile Place #B Redding, CA 96001
OFFICE: (530) 221-DERM (3376) FAX: (530) 221-3378
TLCDerm.com

New Patient Registration

Date: _____

[ ] MALE
[ ] FEMALE
[ ] DECLINED TO STATE

MARITAL STATUS:
[ ] S [ ] M [ ] D [ ] W

LAST NAME **FIRST NAME** **MI**

BIRTHDATE _ _ / _ _ / _ _ _ _

PHYSICAL ADDRESS

SOCIAL SECURITY NUMBER: __ __ __ - __ __ - __ __ __ __

MAILING ADDRESS

CONTACT INFOMATION

MAY WE LEAVE A DETAILED MESSAGE?

CITY, STATE AND ZIP CODE

( ) _____ **[ ] YES [ ] NO**
PRIMARY CONTACT NUMBER

( ) _____ **[ ] YES [ ] NO**
SECONDARY CONTACT NUMBER

EMAIL: If you would like to have access to our patient portal provide your email address.

NAME OF PRIMARY PHARMACY

RACE _____ [ ] Refused to Report

ETHNICITY _____ [ ] Refused to Report

LANGUAGE _____ Do you need a translator: [ ] YES [ ] NO

PRIMARY CARE PHYSICIAN

EMERGENCY & HIPAA RELEASE INFORMATION: PERSONAL HEALTH INFORMATION CAN BE RELEASED TO THE BELOW INDIVIDUAL(S) IF NO DATE STATED THEN NO EXPIRATION WILL BE APPLIED TO NAME GIVEN

NAME **RELATION** **PHONE** **EXPIRATION DATE FOR HIPAA RELEASE**

NAME **RELATION** **PHONE** **EXPIRATION DATE FOR HIPAA RELEASE**

RESPONSIBLE PARTY: [ ] Self [ ] Spouse [ ] Parent Please fill out the following if anyone other than yourself

LAST NAME **FIRST NAME** **MI**

BIRTHDATE _ _ / _ _ / _ _ _ _

MAILING ADDRESS

SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __

CITY, STATE AND ZIP CODE

CONTACT NUMBER ( ) _____

PRIMARY HEALTH INSURANCE INFORMATION

[ ] Self [ ] Spouse [ ] Other: _____

HEALTH INSURANCE COMPANY

Please bring your insurance card to your visit

NAME OF INSURED PERSON

SECONDARY HEALTH INSURANCE INFORMATION

[ ] Self [ ] Spouse [ ] Other: _____

HEALTH INSURANCE COMPANY

Please bring your insurance card to your visit

NAME OF INSURED PERSON

TLC Dermatology Medical Center Inc. - Patient History

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Do you have a pacemaker or defibrillator? ☐ Yes ☐ No
Required **Required**

CURRENT MEDICATIONS: MEDICATION LIST ATTACHED ☐ Yes ☐ No

Medication	Dose	Reason for Medication	Medication	Dose	Reason for Medication

PAST MEDICAL HISTORY: **NONE** ☐

_____
_____
_____

MEDICATION ALLERGIES: **NONE** ☐

_____ Side Effect(s) _____
_____ Side Effect(s) _____
_____ Side Effect(s) _____

SURGICAL HISTORY: **NONE** ☐

_____
_____
_____

HOSPITALIZATIONS: **NONE** ☐

_____
_____
_____

LIST ANY PERSONAL OR FAMILY HISTORY OF MELANOMA OR SKIN CANCER:

_____

_____

SOCIAL HISTORY:

TOBACCO USE:

☐ NON-SMOKER ☐ FORMER SMOKER ☐ OTHER TOBACCO USE

☐ CURRENT SMOKER _____ PACKS PER DAY FOR ____ YEARS.

ALCOHOL USE: ☐ NEVER ☐ MONTHLY OR LESS ☐ 2-4 TIMES A MONTH ☐ 2-3 TIMES A WEEK ☐ 4 OR MORE TIMES A WEEK

HOW MANY DRINKS DAILY: ☐ 1-2 DRINKS ☐ 3-4 DRINKS ☐ 5-6 DRINKS ☐ MORE

REVIEW OF SYSTEMS: ARE YOU CURRENTLY HAVING OR HAVE YOU HAD PROBLEMS WITH ANY OF THE FOLLOWING:
PLEASE CIRCLE YOUR RESPONSE AND DESCRIBE ALL YES ANSWERS

Chills	No Yes	_____	Weakness	No Yes	_____
Fever	No Yes	_____	Nausea	No Yes	_____
Hives	No Yes	_____	Easy Bruising	No Yes	_____
Itching	No Yes	_____	Joint Stiffness	No Yes	_____
Rash	No Yes	_____	Muscle Aches	No Yes	_____
Red Eyes	No Yes	_____	Blanching of Skin	No Yes	_____
Cold Intolerance	No Yes	_____	Difficulty Walking	No Yes	_____
Heat Intolerance	No Yes	_____	Gait Abnormality	No Yes	_____

TLC Dermatology Medical Center Inc.

FINANCIAL POLICY

We at TLC DERMATOLOGY MEDICAL CENTER are committed to providing the highest level of professional medical care and personal service. For every commitment, there is an obligation. Conversely, we feel it is the guardian/patient's responsibility to meet their financial obligation.

As we see patients from many insurance plans, it is impossible for us to know all the covered benefits, co-pays and deductibles for each plan. While it is our intention to assist you, it is still **your responsibility** to ensure that all services rendered by TLC Dermatology Medical Center, on your behalf, are paid in full. In most instances, TLC DERMATOLOGY MEDICAL CENTER INC. will bill your insurance carrier for you.

For patients whose insurance is provided by a plan with whom we are contracted with we will submit the insurance claim, but we expect same day payment of all co-payments, deductibles and non-covered services. If we are contracted with your insurance, we are not able to have you pay cash for services your insurance provider will cover. We are required to bill your insurance for all non-cosmetic services we provide. Any returned checks will be subject to a $35 processing fee.

Full payment on the day of treatment is due on any services that are deemed cosmetic by insurance companies such as; cosmetic injections, laser, peels, cyst removals and skin tag removals.

Proof of eligibility for Medicare and contracted insurance companies is the responsibility of the patient. If the insurance carrier reports the patient is not eligible, the patient is responsible for full payment of charges even if litigation is pending.

Every effort will be made to bill your insurance company for physician services while in the office. If information provided is incomplete or erroneous, the patient is responsible for full payment or must provide the office with corrected information.

Any unaddressed outstanding balances over 90 days will be sent to a collection agency. Outstanding balances are due at time of visit. If a patient has been sent a balance that has been sent to collections the full amount will be due before the patient can be seen at TLC Dermatology Medical Center.

NO SHOW AND CANCELATION POLICY

Patients who fail to show for their scheduled appointment or did not notify the office of their cancelation **24 business hours before** their appointment time shall be subject to a fee. Regular skin check and Medi-spa appointment fee is $50. Blue Light appointment fee is $75. In the event of an actual emergency and prior notice could not be given, consideration will be given and a one-time exception may be granted.

These fees are not billable to insurance and will be the patient's responsibility.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to TLC DERMATOLOGY MEDICAL CENTER INC. for any services furnished by that office. I authorize 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 release of the information to the insurer 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 patent 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.

HEALTH INSURANCE PORTABILITY ACCOUNTABLITY ACT (HIPAA) ACKNOWLEDGMENT

I acknowledge that I can request a copy of TLC DERMATOLOGY MEDICAL CENTER INC. Notice of Privacy Practices.

RX CONSENT

I authorize TLC DERMATOLOGY MEDICAL CENTER INC. and the staff to view my external prescription history via the RxHub service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE _____ DATE _____

TLC Dermatology Medical Center Inc.

CONSENT FOR THE GENERAL MINOR PROCEDURE NECESSARY TO THE PRACTICE OF DERMATOLOGY

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment is recommended.

By signing this from you are consenting for the following treatments that are done in this office. This consent will remain fully effective until revoked in writing.

- I understand that the destruction with liquid nitrogen of actinic keratosis, inflamed seborrheic keratosis, warts and molluscum may be deemed necessary by the provider.
- I understand that the intralesional injection of Kenalog for the treatment of keloids, hypertrophic scars, cysts, acne, psoriasis, atopic dermatitis, and alopecia may be deemed necessary by the provider.
- I understand that any of the above procedures may have some unwanted effects which include but are not limited to permanent scarring, discoloration of the treatment site, infection, atrophy, bleeding, blisters, skin redness and skin thinning.
- I authorize the use and administration of medications and other treatments including the use of cryosurgery with liquid nitrogen, hyfercation, and the injection of Kenalog should these be deemed advisable or necessary for treatment by the provider.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any tests ordered or procedures. If you have any concerns regarding any tests or treatments recommended by the provider, we encourage you to ask questions before treatment is done.

OFFICE VISIT DETAILS

All office visits and additional procedures will be billed to your insurance. We are unable to let you know how much your insurance company will cover and/or pay. If you have any questions regarding insurance payments, please call your insurance provider. *All patients have the option to do a full skin exam at each visit and we encourage each patient to do so.*

Any diagnosis, procedures, discussion or even looking at a lesion by the provider will be billed to your insurance.

An office visit includes a skin exam, diagnosis of any skin issues, and/or any medications called in that may be needed for treatment. Any of the following procedures will be an *additional charge to the office visit*.

Cryo Treatment	Biopsies (shave, punch)
Surgeries (excision, EDC)	Hyfercation
Kenalog injections	

The following procedures are *not covered by insurances*, they are considered cosmetic and will not be billed to your insurance company. All payment is due at the time of service for the following:

Laser treatments	Peels
Skin tag removal	Cosmetic Injections (Fillers, Xeomin, Jeuveau)

At this time Medicare is not covering benign skin lesion removals, such as cysts and lipomas, and will be cash pay. Please discuss your options with the provider. Multiple treatment of any procedure may occur to reach the desired outcome, each treatment will be billed to both you and your insurance.

Patient Signature: _____Date: _____

If patient is under 18 years of age or unable to authorize consent:

Signature of parent or legal guardian: _____ Date: _____