DR. LEONARD KIM DERMATOLOGY

PATIENT INFORMATION

Name_____ Date of Birth_____Age_____
Last First

Gender M/F_____Marital Status S/M/D_____SSN_____
Address_____
City_____State_____Zip Code_____
Home Phone_____Cell_____

Race/Ethnic Group (optional)_____
Smoking Status_____Alcohol Use_____

Occupation_____Employer_____
Office Phone_____E-mail_____
Emergency Contact_____Phone_____

How would you like to be contacted? Home_____Cell_____Work_____
Leave a message? Y/N

Referring Physician_____Primary Physician_____

Person Responsible for Payment_____
Relation to Patient_____
Address_____
City_____State_____Zip Code_____
Home Phone_____Cell_____
Date of Birth_____SSN_____

INSURANCE INFORMATION

Insurance Company_____
Policy Number_____
Group Number_____

PHARMACY INFORMATION

Pharmacy Name_____
Pharmacy Address_____Zip_____
Pharmacy Phone_____Fax_____

Sign:_____ Date_____

MEDICAL HISTORY

Patient Name_____Date_____

Reason for Visit_____

Please list all medical Allergies
1_____2_____3_____
4_____5_____6_____

Please list all current medications and doses with milligrams
(including herbals and over the counter)
1_____2_____3_____
4_____5_____6_____

Do you have or ever have had any of the following conditions?

A: Lungs
- Bronchitis ☐
- Asthma ☐
- Cough ☐

B: Cardiovascular
- High Blood Pressure ☐
- Heart Attack ☐
- Irregular Heartbeat ☐

C: Endocrine
- Diabetes ☐
- Thyroid Condition ☐

D: Neurologic
- Seizures ☐
- Headaches ☐

E: Gastrointestinal
- Nausea/Vomiting ☐
- Reflux ☐

F: Hematology
- HIV + ☐

G: Skin
- Psoriasis ☐
- Phlebitis ☐

Immunizations: Td/Tdap Y/ N HPV: Y/N Patients 65+: Pneumonia Vaccination Y/N

SKIN/GENERAL QUESTIONS
Have you had skin cancer? Y/N_____ If yes, what type?_____
Has anyone in your family had skin cancer? Y/N If yes, who_____

Have you ever had anesthesia/dental anesthesia? Y/N____
Any reactions?_____
Please answer the following questions:
Do you bleed easily?_____
Are you pregnant?_____
Do you have artificial joints or valves?_____
Patient Signature_____

LK | MD

DERMATOLOGY

COSMETIC QUESTIONNAIRE

We'd love to learn more about your top cosmetic concerns so we can recommend the best treatments for you. Tell us about your areas of concern or interest.

FACE

- ☐ Fine lines & wrinkles [Botox]
- ☐ Facial volume [Juvederm products including Vollure, Volbella]
- ☐ Lip enhancement [Lip filler, Lip flip]
- ☐ Dark spots, age spots
- ☐ Redness, Facial veins
- ☐ Acne scars, skin rejuvenation [Fraxel laser resurfacing, microneedling with PRP, chemical peel]
- ☐ Hydrafacial

BODY

- ☐ Excessive sweating [Botox for hyperhidrosis]
- ☐ Hair restoration [PRP for hair loss or thinning]
- ☐ Unwanted hair [laser for hair removal]
- ☐ Leg veins [Sclerotherapy]
- ☐ Tattoo removal
- ☐ TMJ or Migraines [Botox]

WHAT COSMETIC PROCEDURES HAVE YOU HAD BEFORE (IF ANY?)

ARE YOU INTERESTED IN A TOPICAL SKIN CARE REGIMEN? YES / NO

WOULD YOU LIKE US TO CONTACT YOU FOR FUTURE SEASONAL PROMOTIONS? YES / NO

PATIENT NAME:_____

DATE:_____

EMAIL:_____

PHONE:_____

DR. LEONARD KIM DERMATOLOGY

Consent for Treatment:

By signing this form, you consent to our disclosure of protected information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practice provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review the information before you sign this consent and we encourage you to read it in full. Your signature indicates you received this Notice. Our Notice of Privacy Practice is subject to change.

Financial Statement:

By signing this for you are accepting direct responsibility for all financial obligations to Dr. Leonard H. Kim, MD for services rendered by this office. Payment is expected at the time of service or upon receipt of statement (for charges due after insurance). Financial obligations include deductibles, co-insurance, charges not covered by your insurance, cosmetic procedures, and others. It is your responsibility to verify if the doctor is contracted with your insurance company and to pay the charges in full if he/she is not contracted. Some Laboratory/Pathology charges are billed directly by the Laboratory. A 1.0% per month service charge will be added to overdue balances as well as a $25 service charge will be added to returned checks. This assignment remains in effect until revoked in writing. A copy of this paper shall be as valid as the original. Your signature below indicates that you understand and accept this policy.

Cancellation/No Show Policy:

By signing this form, you are agreeing to our office's cancellation/no show policy. Our cancellation/no show policy is as follows: For any cancellations, rescheduling, or no shows, our office must receive at least 24 hours notice prior to the appointment time. If notice is not received within a timely fashion, there will be a $75 fee.

Patient Signature_____Date_____

DR. LEONARD KIM DERMATOLOGY

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 provides safeguards to protect your privacy. These safeguards include 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 or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. For this reason, our practice has adopted the following policies:

(1) Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

(2) It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

(3) The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPAA.

(4) The patient understands and agrees to inspections of the office and the review of documents that may include PHI by government agencies or insurance companies in the normal performance of their duties.

(5) The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

(6) Your confidential information will not be used for the purposes of advertising or marketing of products, goods, or services. Such prohibition does not include treatment/product samples or goods of nominal value.

(7) The practice agrees to provide the patient with access to their records in accordance with state law.

(8) The practice may change, add, delete, or modify any of these provisions to better serve the needs or both the practice and the patient.

I,_____, do hereby agree to the terms set forth above and any subsequent changes in office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

DR. LEONARD KIM DERMATOLOGY

PATIENT-PHYSICIAN AGREEMENT

Thank you for selecting Dr. Leonard Kim Dermatology for your medical care. We look forward to assisting you with your health needs. In order to prevent any misunderstanding concerning your medical care, including the responsibility for payment for medical and surgical services provided to our patients, the following information is supplied:

The patient is responsible for assisting the physician with management of the patient's healthcare needs. This includes maintaining compliance with diagnostic and treatment recommendations. The patient or his/her guarantor is responsible for payment of services provided by the Dr. Leonard Kim Dermatology at the time of service. The only exception is if The Dermatology Institute of Southern California has contracted with your insurance company to accept the insurance payment as payment in full after all deductibles have been met and co-payment has been paid. Tests run in the office or which are referred to an outside facility, such as pathology, laboratory, radiology, or other diagnostic tests may be billed separately and will be in addition to the office visit charges.

Dr. Leonard Kim Dermatology charges a cancellation charge for appointments canceled with less that 24 hours notice as well as for not showing up for an appointment. Charges may apply for telephone consultations and/or e-mail consultations.

HMO/PPO or Contracted Insurance Coverage.

If you have insurance coverage through a company that we have contracted with, we require a copy of your insurance card and driver's license (or other photo identification), your mailing address and payment of your co-payment at the time of service. An additional billing fee may be charged for co-payment not paid at the time of service. If your annual deductible for the calendar year has not been met, you will be responsible for any charges incurred payable at the time of service.

Please be aware that your health insurance policy is an agreement between you and your insurance company. All charges are your responsibility, whether or not you have insurance. Not all services are covered under all contracts. Because there are so many different insurance plans, it is not possible for us to know the specific details of your coverage. Keep in mind that care your doctor believes is medically necessary may not be considered to be a “medical necessity” under your insurance plan. In some cases, your doctor might decide that you need medical care that is not covered by your insurance policy.

Medicare

Our physicians are participating Medicare providers. Office visits with a doctor are covered under Part B of the Medicare program Medicare pays 80% of their allowable charges after you pay your annual deductible for the calendar year, and you are responsible for paying the other 20%. If you have supplemental insurance, we require a copy of your insurance card and insurance mailing address. We are not contracted with Medi-cal.

Authorization to Perform Lab Tests

With respect to medical care and services provides and to be provided by Dr. Leonard Kim Dermatology and physicians providing Medical and Professional services it is agreed and understood: I hereby give Dr. Leonard Kim Dermatology authorization to perform the required laboratory or pathology test(s) that have been ordered by the doctor. Depending on your insurance, you may be billed separately from your office visit by the lab. Some insurance companies may require you to use a particular lab or hospital for tests. You may then choose to pay for your our own lab tests, or go to the laboratory/hospital where your insurance require that you go. I hereby certify that I have been notified by Dr. Leonard Kim Dermatology about the name, address and charges of the laboratory performing these tests. I also understand these bills may or may not be combined with the office visit. Furthermore I understand that extra charges will be added to the charges of Laboratory for professional interpretation by the physician and handling fees.

Billing and Collections Policy

You will receive a statement after your insurances company has processed your claim. If you full balance is not paid within 30 days of receipt of our statement, you will be charged a finance charge amounting to a 18% annual percentage of the unpaid balance on your account (which corresponds to a monthly periodic rate of 1.5%). If payment in full is not received 30 days after the date of your second statement, your account will be automatically forwarded to a collections agency for further action. Any accounts forward to the collections agency becomes the property of the collection agency and are subject to additional fees as allowed by law. Any balances that your insurance carrier has not acted upon within 45 days will be transferred to your responsibility.

I have read all the information above and agree that, regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered.

In the event that my insurance company is billed, I authorize payment of medical benefits to be paid directly to Dr. Leonard Kim Dermatology I authorize the release of any medical information necessary to process my claims. A photocopy of this agreement shall be considered as effective and valid as the original.

Patient name: _____

Name of responsible party (if other than patient):

_____

Signature of patient/responsible party: _____ Date: _____