ULMER & WU DERMATOLOGY

DOUGLAS K. ULMER, M.D. **JAMES WU, M.D.** **KELLY SLATER DEGREE, N.P.**

1045 ATLANTIC AVE SUITE 819
LONG BEACH, CA 90813
TEL: 562-435-5621 FAX: 562-437-3121

PLEASE PRINT

Patient Name *(last)* _____ *(first)* _____ Age _____ M / F Birthdate _____

Home Address _____ Cell Phone _____

_____ zip _____ Home Phone _____

Occupation _____ Email _____

SSN _____ CA Driver's License No _____ Medicare No _____

Name of Responsible Party for Minor _____ Relationship _____

Address _____ Cell Phone _____

_____ zip _____ Home Phone _____

Spouse or Closest Relative Name _____ Relationship _____

Address _____ Cell Phone _____

_____ zip _____ Home Phone _____

Primary Insurance Co Name _____ Phone number _____

ID # _____ Group # _____

Name of Insured _____ SSN of Insured _____ Birthdate of Insured _____

Relationship to Patient □ Self □ Spouse □ Parent □ Other Employer _____

Name of Primary Care Physician _____ Phone _____

Referred by _____

CONSENT + AUTHORIZATION FOR TREATMENT

By my signature below, I authorize evaluation and treatment by Dr. Ulmer, Dr. Wu, Kelly Slater DeGree, NP, and their staff.

I understand that many dermatological conditions are chronic and require ongoing care. All medications have side effects and there are risks to any medication prescribed.

Dermatologists frequently diagnose skin growths by performing a skin biopsy (sampling a small area of skin under local anesthesia) and treat skin growths by freezing, cauterization with a heated needle, and/or cortisone injection. I understand that there are risks to any procedure and that these risks include, but are not limited to:

- Temporary or permanent discoloration
- Scarring
- Pain
- Infection
- Bleeding
- Nerve damage.

I consent to having these procedures done as part of my care and treatment.

I understand that full skin examinations for cancer screening are performed if scheduled in advance.

I recognize that most visits are for consultation and evaluation of a specific condition and that surgeries, even minor removals, may need to be scheduled at a separate time. If time allows, the physician is happy to add this on to any appointment. This authorization and consent shall remain in force for this visit and all future visits to the office.

This consent will remain in effect until revoked by me in writing.

_____ _____

Signature **Date**

MEDICAL HISTORY

Reason for today's visit _____

Height _____ Weight _____

Medical Conditions: (please indicate with an "X" all that apply)

Skin
- □ Basal cell skin cancer
- □ Squamous cell skin cancer
- □ Melanoma
- □ Psoriasis
- □ Eczema
- □ Acne
- □ Scarring/keloids
- □ Other _____

Cardiovascular
- □ Heart attack
- □ Irregular heart beat
- □ Chest pain/tightness
- □ Heart murmur
- □ Shortness of breath
- □ High/Low blood pressure
- □ Pacemaker
- □ Stent or artificial valve

Hematologic/Metabolic
- □ HIV/AIDS
- □ Hepatitis C
- □ Anemia
- □ Bleeding disorders
- □ Autoimmune disease
- □ Thyroid disease
- □ Diabetes
- □ Kidney disease

Eye, Ear, Nose
- □ Blurry vision
- □ Dry eyes
- □ Glaucoma
- □ Ear disease
- □ Nasal allergies
- □ Nasal obstruction
- □ Nose bleeding
- □ Sinus Disease

Gastrointestinal
- □ Gastritis
- □ Ulcers
- □ Colitis
- □ Diverticulitis

Musculoskeletal
- □ Arthritis
- □ Fibromyalgia
- □ Arthritis
- □ Artificial joints

Pulmonary
- □ Asthma
- □ COPD
- □ Pneumonia
- □ Tuberculosis

Neurologic/Psychiatric
- □ Seizures
- □ Headaches
- □ Depression
- □ Schizophrenia/Bipolar

Do you use:				
	Alcohol	□ Yes	□ No	Frequency _____
	Tobacco	□ Yes	□ No	Frequency _____
	Aspirin	□ Yes	□ No	Frequency _____
	Illicit drugs	□ Yes	□ No	Frequency _____

Are you □ Pregnant □ Trying to conceive □ Breastfeeding

Family History (Indicate any conditions of immediate family members - mother, father, siblings, children)
- □ Heart disease
- □ Cancer (type) _____
- □ Melanoma
- □ Hypertension
- □ Autoimmune disease
- □ Non-melanoma skin cancer
- □ Stroke
- □ Eczema
- □ Asthma
- □ Diabetes
- □ Psoriasis
- □ Seasonal allergies/hay fever

Surgical/Procedure History (list all surgeries including cosmetic and laser procedures)

Date	Type	Physician	Complications

Have you or anyone in your family had problems associated with surgery?
□ Bleeding □ General anesthesia □ Lidocaine allergy □ Poor scarring □ Other _____

Hospitalizations (Other than surgery)

Date	Reason/Illness	Physician	Complications

Medications (Include vitamins, diet pills, birth control, herbal supplements, etc.)

Name	Strength/Dose

Allergies

Medication	Reaction

Are you allergic to: Latex □ Yes □ No
Adhesives □ Yes □ No

PATIENT PRIVACY POLICY CONSENT

This consent will apply to all healthcare providers employed by and acting for the benefit of this office who conduct, plan and direct treatment and follow-up and may be involved in treatment, directly or indirectly. In the course of providing services to you, this office will create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct day-to-day health care operations. The Notice of Privacy Practices describes the uses and disclosures in detail. The use and disclosures of your health information may include care and services, follow-up care from another health professional, disclosure of your information for billing purposes or processing claims for obtaining payment, or submission of claims to a third-party or insurer. You have the right to restrict the use of disclosure made for purposes of treatment or health care operations, but this office is not obligated to agree to these restrictions. If this office does agree, however, the restrictions are binding. You may revoke this consent in writing at any time, except to the extent that this office has taken action relying on this consent.

I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and health care operations.

Date: _____ Patient Name: _____

_____
Signature of patient or legally authorized individual

_____ _____
Print name if signed on behalf of the patient Relationship - parent, legal guardian

Please initial and provide any additional information as required to enable us to appropriately use and disclose your protected health information for the following:

I agree to be contacted for appointments, biopsy/lab results, or follow up information regarding my care by:

□ Phone Preferred number _____ Initials _____

□ Ok to leave message/voicemail Initials _____

□ Email Initials _____

□ Text Initials _____

I agree to allow the practice to use and disclose information regarding my care as needed to family. Initials _____

These consents will remain in effect until revoked by me in writing.

_____ _____
Signature **Date**

Choose 1 CONSENT FOR USE OF PHOTOGRAPHS

I consent for medical photographs to be taken of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Ulmer Dermatology, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Ulmer Dermatology at 562-435-5621.

1. I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes at Ulmer Dermatology and to be used in my medical record.

OR Patient Signature _____ Date _____

2. I agree for my image to be shown for teaching purposes AND to be used for my medical record but NOT FOR medical publication.

OR Patient Signature _____ Date _____

3. I agree to the use of my image for medical records ONLY.

Patient Signature _____ Date _____

FINANCIAL POLICY

Payment is expected as services are rendered. We accept cash, personal check Visa and MasterCard. **IT IS YOUR RESPONSIBILITY TO LET US KNOW OF ANY CHANGES TO YOUR INSURANCE.** Please initial whichever policy applies to you below:

- **Cash and out-of-network PPO:** If you are a cash patient or if your physician is not a contracted provider with your insurance company, we will collect payment at the end of your visit. All visits are charged a standard consultation fee plus additional fees for any procedures performed at the time of your visit. Feel free to discuss these charges with your doctor ***prior*** to the procedure. The office visit will be applied towards your **out-of-network benefits** and any reimbursement will be sent directly to you.Otherwise, we will provide you with a form for you to submit to your insurance company for direct reimbursement. You must fill out your personal insurance identification information on our form and submit it to your insurance company; the claims address can be found on the back of your insurance card. **Cosmetic procedures will not be billed to insurance and are patient responsibility.**

_____ Initials

- **In-network PPO/HMO patients:** For those patients who are covered by insurance and seeing a physician contracted with your insurance company, we will be happy to bill on your behalf, whenever medically applicable. Patient responsibility will depend on your contract with your insurance company and apply to any deductible or coinsurance amounts that you must satisfy. 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. Verification of benefits is not a guarantee of coverage. Medical necessity is up to the determination of your insurance provider. You, the patient, may be responsible for services even if the doctor is contracted with patient's insurance company if the service is deemed not medically necessary by your insurance plan.

_____ Initials

- **Medicare patients:** We will bill Medicare on your behalf as long as you have not signed your Medicare over to an HMO. Medicare will then forward your claim to your secondary as long as you have a **crossover** set up. If you do not have a secondary **or** your secondary does not pick up Medicare's allowed amount at 100%, you may have some responsibility once we have received payment from your insurance. **Cosmetic procedures will not be billed to insurance and are the patient responsibility.**

_____ Initials

Any outstanding balance that is your responsibility is expected to be paid in full within **60 days.** Payment plans are available, just ask and we would be happy to work with you.

All patient refunds will be kept as a credit on the patient's account toward their next visit unless a refund request is initiated by the patient. Refunds are up to the discretion of the office manager, and the following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the patient's account, and there are no outstanding balances on the patient's account.

All returned checks will be subject to a $25.00 fee per occurrence. Cancellations made with less than 24 hours notice will be subject to a $50-$150 cancellation fee.

_____ Initials

I understand that I will be expected to pay for all applicable fees the day of service. I understand that I am responsible for any balances not covered by insurance. I will assume responsibility of notifying this office of any changes in insurance coverage. I authorize my insurance company to pay directly to my physician the amount due in my pending claim for basic medical, major medical or surgical treatment (if applicable). I authorize the office Ulmer Dermatology to release to any company providing me with medical insurance any information, including the diagnosis and the records of all treatments and/or examinations provided to me by my physician for the purpose of billing (if applicable).

I have read, understand, and agree to the above policies.

_____ _____

Signature **Date**

JAMES G. WU, M.D.
Diplomate American Academy of Dermatology

DOUGLAS K. ULMER, M.D.
Diplomate American Academy of Dermatology
Diplomate American Board of Dermatopathology

SUSAN SLEEP, M.D.
Diplomate American Board of Internal Medicine
Board Certified American Academy of Aesthetic Medicine

DERMATOLOGY • DERMATOPATHOLOGY • DERMATOLOGICAL SURGERY • COSMETIC AND LASER SURGERY
MOHS MICROGRAPHIC SURGERY • SPECIALIZING IN ACNE TREATMENT • SUPERFICIAL RADIOTHERAPY

ST. MARY'S PROFESSIONAL BUILDING
1045 ATLANTIC AVENUE SUITE 819 • LONG BEACH, CALIFORNIA 90813
TELEPHONE – (562) 435-5621 • FAX - (562) 437-3121

Ulmer Dermatology Financial Agreement

Welcome to our office. This form is intended to clarify your financial responsibilities. We value our patients and are committed to providing the highest quality service from our board certified dermatologists, dermatopathogists, dermatological & cosmetic surgeons. Thank you for choosing our office for your dermatological needs.

1. I understand that payment for medical services is due the day the service is rendered. Payment for cosmetic procedures may be due (2) weeks prior to the date of the procedure. If payment for cosmetic procedures is not requested (2) weeks prior to the date of the procedure, then payment is due the day the service is rendered. _____
   patient initial
2. **I understand and agree that I am responsible for payment for all charges on my account.** It is preferable that you pay in full on the day you are seen. This may be done with a credit card, check or cash. **If you are unable to pay in full on the day you receive service, you will be asked to sign a credit card authorization form.** Should you not fulfill your financial responsibilities to this office after 30 days, your credit card will be charged for the remaining balance on your account. _____
   patient initial
3. This agreement will not compromise your ability to dispute a charge.
4. If you have any questions about this payment method, do not hesitate to ask.
5. I understand and agree that if my account is sent into collection action, I will be responsible for all the costs of such action (collection agency, small claims court, and attorney's fees included).
6. Missed, changed, cancelled or rescheduled appointments may have additional costs.

I have been informed of **Ulmer/ Sleep/ Wu Dermatology** Financial Agreement policies.

Signature of Responsible Party Date

Witness Date

Information Regarding PPO Billing Practices

In an effort to avoid any billing confusion or surprises for our patients, we are providing this information to our PPO patients who are seeing our physician or PA and using their insurance.

Health insurance is unlike any other insurance you buy: even after you pay premiums, there are complicated, continuing costs - co-pays, deductibles, and co-insurance. Understanding these costs will hopefully help you understand any bills you may receive from our office.

Co-pay: Your co-pay is a predetermined rate you pay for health care services at the time of care. Co-pays for specialists are often more than primary care doctors. We are required by your insurance company to collect your co-pay at the time of service. Please come prepared to pay your co-pay at the time of service so we do not have to cancel or reschedule your appointment.

Deductible: The deductible is how much you pay before your health insurance starts to cover a larger portion of your bills. Even if a visit or procedure is medically necessary and "covered by your insurance," you will still be responsible for paying the doctor in full for any medical bills you incur until your deductible is met. This amount is in addition to your co-payment that was collected at the time of service. The amount you pay will be applied towards your deductible amount. In general, if you have a $1,000 deductible, you must pay $1,000 for your own care out-of-pocket before your insurer starts covering a higher portion of costs. The deductible resets yearly.

Co-insurance: Co-insurance is a percentage of a medical charge that you pay, with the rest being paid by your health insurance plan, AFTER your deductible has been met. For example, if you have a 20% co-insurance, you pay 20% of medical services, and your health insurance will cover 80%.

If you are seeing a contracting provider and using your insurance, we are bound by our contract with your insurance provider.

- We are not allowed to adjust or waive any co-payments, deductibles, or co-insurance. This is considered medical insurance fraud and doing so will result in us losing our contract with your insurance provider.
- **The prices for services are determined by your insurance company. When opting to use your insurance coverage you agree to their terms and conditions.** Our cash prices may be less than the set insurance price for some procedures. You may inquire about cash prices and choose to see our providers as a cash patient. However, if you do so, you will NOT be able to submit the claim to your insurance company and the amount you pay to our office will not be applied to your deductible. The cash amount will be due at the time of service.

Procedures (including but not limited to biopsies, excisions, suturing, freezings, cauterizations, injections, acne surgery, etc) are not included in the price of an office visit and will have an additional charge associated with them. This price is also determined by your insurance company. You may have a separate deductible for these procedures. Therefore, your insurance may pay for the office visit portion of the charges but not the procedures until this deductible is met.

While we are happy to assist you with your insurance questions, it is YOUR responsibility to understand your insurance coverage. More detailed information about your plan's co-pay, deductible, and co-insurance can be obtained by calling your insurance company or referencing the contract you received when you signed up for your plan.

I understand the above and agree to pay all co-pays, deductibles, or co-insurance payments related to my visits.

_____ _____

Signature Date

ULMER & WU DERMATOLOGY
1045 ATLANTIC AVENUE, SUITE 816, 819
LONG BEACH, CA 90813
562.435.5621

AUTHORIZATION TO CHARGE CREDIT FOR BALANCE

Patient Name _____ Account#_____

Patient Address_____

Patient Phone_____

I hereby authorize Douglas K. Ulmer M.D., Inc. and associates to charge the credit card designated below for the remaining balance of the above patient. This payment will be made 30 days after the office visit.

I certify and attest that as an approved user of this credit card, I authorize Ulmer & Wu Dermatology Inc. and associates to debit the credit card account listed below for the total noted above. I understand that this transaction is subject to authorization by the issuing bank and the issuance of an authorization approval code by same. I further understand that by signing this form I agree to pay any amount due to Ulmer & Wu Dermatology Inc. and/or associates in the event that this transaction is subsequently charged back to Ulmer & Wu Dermatology Inc.

Cardholder Name _____
(as it appears on card)

Cardholder Signature _____

Cardholder Mailing Address_____

Credit Card Type (circle one) VISA OR MasterCard

Credit Card Number_____ Exp. Date_____

CVV Code _____ (3 numbers)