

ADAM M. ROTUNDA, M.D.

A PROFESSIONAL CORPORATION

MOHS MICROGRAPHIC & DERMATOLOGIC SURGERY

Name: _____
Last First M.I.

Address: _____
Street City State Zip

Telephone: (_____) _____ (_____) _____ (_____) _____
Home Mobile Work ext

Responsible Party: Self Other: _____ Relationship: _____
(i.e., who pays bill for any patient portion)

Primary Care Physician: _____ Telephone: (_____) _____

Date of Birth: _____ Sex: M F Ethnicity: _____

Marital Status: Single Married Divorced Widowed Legally Separated

Social Security Number: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone: _____

Patient Email Address (if you have one): _____

Pharmacy Name & Location: _____ Pharmacy telephone: _____

EMPLOYMENT STATUS: Full Time Part-Time Self-Employed Retired Not employed Student

Employer Name: _____

Employer Address: _____
Street City State Zip

INSURANCE INFORMATION

Please check one:
 Self Pay (no insurance) Patient IS the policy holder Patient IS NOT the policy holder (fill out below)

If the above named patient is not the primary policy holder, please fill out the following:
INSURED INFORMATION

Name: _____
Last First M.I.

Date of Birth: _____ Social Security Number: _____ Sex: M F

Address: _____
Street City State Zip

Telephone: (_____) _____ (_____) _____ (_____) _____
Home Mobile Work ext

Patient's Relationship to insured (i.e. child, spouse, etc.): _____

We are privileged to have you at our practice, who can we thank for referring you to us?

Physician (Dr. _____) Family/Friend (Name: _____)

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Patient Name: _____ Date of Birth: _____/_____/_____

Age: _____

Why are you seeing the dermatologist today? _____
What prior treatments have you used for this condition? _____
What part(s) of your body is (are) affected? _____
How long have you had the problem? _____
Has this problem resulted in: itching bleeding open wound
Are you having any pain associated with the reason for your visit today? Yes No
Describe the pain: burning stabbing sharp numb unable to describe
Location of the pain _____
How long have you had the pain? _____
How often does it occur? _____

Past Personal Skin problems:

- Abnormal moles
- Melanoma
- Skin cancer (type): _____
- Eczema or dermatitis
- Psoriasis
- Connective tissue disease
- Blistering disorders
- Thick scars or keloids
- Other - specify: _____

Family History of Skin Problems:

- Melanoma
- Skin cancer (other)-specify type _____
- Eczema or dermatitis
- Psoriasis
- Connective tissue disease
- Other - specify: _____

Allergies and Intolerances (if none, check here) :

Current Medications (including non-prescription and vitamins):

Do you have to take antibiotics before routine dental procedures: Yes No

Do you have any of the following:

- Anemia
- Arthritis
- Artificial heart valve
- Artificial joints
- Asthma
- Bleeding disorders
- Cancer, type: _____
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Gout
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- High blood pressure
- HIV infection/AIDS
- Kidney disease
- Liver disease
- Osteoporosis
- Pacemaker or Defibrillator (circle)**
- Pneumonia
- Sexually transmitted disease
- Sores in mouth
- Stomach ulcer
- Stroke
- Thyroid problems
- Tuberculosis
- OTHER (ie significant surgeries or other medical illnesses)**
- None of the above**

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What are your Hobbies? _____

Habits :

Alcohol: No Yes (Amount per week): _____

Tobacco: No Yes (Amount per week): _____

Women Only

Postmenopausal

Are you pregnant? Yes No

Are you trying to become pregnant? Yes No

Are your menstrual periods regular? Yes No

Birth control method: _____

Consent and Authorization for Treatment

By my signature below, I authorize evaluation and treatment by Adam M. Rotunda, M.D. I hereby give these physicians authorization to perform the required laboratory or pathology test(s) that have been ordered. I understand that dermatology is an inexact science and many conditions are chronic and require ongoing care. All medications have potential side effects and there are risks to any medication prescribed.

Dermatologists frequently treat skin growths by freezing, cauterization with a heated needle, biopsy or excisional biopsy by cutting the lesion out, and/or cortisone injections. I understand that there are risks to any procedure performed on the skin and that these risks include, but are not limited to: permanent discoloration of the skin, scarring, pain, infection, bleeding, and/or nerve damage. I consent to any of these procedures as part of my treatment. I understand that full skin examinations for cancer screening are performed if scheduled in advance. I recognize that most visits to the office are for consultation and evaluation, and that surgeries, even minor removals, may need to be scheduled at a separate time. **This authorization and consent shall remain in force for all future visits to this office.**

Patient Signature: _____

Date _____

Physician Signature: _____

Date _____

Privacy Practice Acknowledgement (HIPAA)

A copy of this notice is available to you. Please ask the reception staff if you would like one. By signing below, I acknowledge that I have been offered a copy of our Notice of Privacy Practices.

By signing below, I authorize a physician at Pacific Dermatology or one of their staff members to leave a detailed message in reference to any items that assist the practice in carrying out healthcare operations. If you **do not** wish to be contacted at a specific location, please indicate below:

Home Phone: Do not contact me here

Mobile Phone: Do not contact me here

Work Phone: Do not contact me here

E-mail: Do not contact me here

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc.)

Name: _____

Relationship: _____

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Patient Name: _____

Release of Medical Information

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and to process insurance claims, insurance applications, prescriptions, or to complete any other medical operations as necessary.

Signature: _____ Date: ____/____/____

Financial Policy – Medicare Patients Only

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

Signature: _____ Date: ____/____/____

Financial Policy – All Patients, Including Medicare

Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments, co-insurance and deductibles will be collected. Our office **does not** accept Cal-Optima/Medical/Medicaid, does not accept some PPO insurance plans, and may not accept other plans. Patients are responsible to check our participation with their plan before their visit. The patient is responsible for any and all charges not paid for by their insurance company. If you must cancel or reschedule an appointment, please do so at least 24 hours before the scheduled appointment time.

Depending on your insurance, you may be billed separately from your office visit by the lab for laboratory or pathology test(s) or professional interpretations that have been ordered, which may or may not be combined with the office visit fees.

You will receive a statement after your insurance company has processed your claim. If your 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 (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. In the event a suit is necessary to enforce collection all costs and attorney fees that the court may deem just and proper will be charged to you. This authorization is valid until revoked in writing. I have read and understand the financial policy statement:

Signature: _____ Date: ____/____/____

**** THE FOLLOWING IS NOT FOR MEDICARE PATIENTS ****

If you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient. We have implemented a similar policy. Your credit card information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you may be charged to your credit card, and a copy of the charge will be mailed to you. For elective procedures, payment for the entire amount is due at the time of the visit. You will no longer have to write out and mail us checks and it will decrease the statements that we have to generate and mail out. This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

You will NOT be charged without prior notification. I hereby authorize Adam M. Rotunda, to charge outstanding balances on my (circle):

Visa Mastercard Discover Account #: _____ Expiration Date: ____/____

Name on card (please print): _____

Signature: _____ Today's Date : ____/____/____

Consent for Surgical Procedure

I, _____, hereby authorize Adam M. Rotunda, M.D. to perform the following procedure(s) in the office:

- Mohs Micrographic Surgery**
- Excisional Surgery** (ie melanoma and other skin cancer surgery, abnormal moles, birthmarks, cysts, lipomas, nail surgery)

On the following site(s):

_____/_____
Patient initials / MD initials

- Repair of the wound following Mohs Surgery** (primary closure, skin flap or graft, or combination of the above) on the following site(s):
- _____

_____/_____
Patient initials/ MD initials

- Other:** _____ on the following site(s): _____

_____/_____
Patient initials/ MD initials

I fully understand what will happen to me during the day of my operation. The nature of my diagnosis and surgery, benefits of surgery, alternative procedures available, and possible risks or complications have been discussed, and any questions I have regarding the above have been answered satisfactorily.

I have been informed of the possible risks or complications of surgery. Possible risks or complications include, but are not limited to:

- | | |
|----------------------------|--|
| 1. Scarring | 5. Change in skin color (compared to the surrounding skin) |
| 2. Bleeding | 6. Infection |
| 3. Reactions to anesthesia | 7. Nerve damage (both motor and sensory) |
| 4. Skin thinning | 8. Other unknown risks as a result of the procedure |

I consent to local anesthesia. If other types of anesthesia are planned, an anesthesiologist will discuss the benefits, risks and complications to me.

A D A M M . R O T U N D A , M . D .

A P R O F E S S I O N A L C O R P O R A T I O N

M O H S M I C R O G R A P H I C & D E R M A T O L O G I C S U R G E R Y

I allow Dr. Rotunda, or his designated associate to photograph or videotape my skin lesion, any tissue removed, and/or the surgical procedure. The **primary purpose of these photographs is in the correspondence of the referring physician**, but these photographs or videos may be used for educational purposes and may be published in professional journals or medical books.

In such an event, I **will not be identified by name and any unique physical attribute** (eyes, tattoos, birthmarks, etc) will be removed. Furthermore, I expect no compensation for these photographs or videos and waive all rights, title, or interest to any claims for payment or royalties. I also release Dr. Rotunda from any liability in connection with the use of such photographs or videos.

I also do hereby authorize and direct Adam M. Rotunda, MD to retain and obtain complete custody and control of all medical records, tissue slides, photographs, videos, or medical charts pertaining to any medical and surgical treatment of skin cancer received by me from any physician or medical personnel within the past seven years. Another physician, who acts as a peer reviewer for Dr. Rotunda, may review my chart with confidentiality.

This authorization is given for the purpose of facilitating Adam M. Rotunda, MD in his care and treatment of me as his patient. This shall supercede all previous authorizations or agreements executed by me.

Patient Signature

Date

Witness Signature

Date

MD Signature

Date