PATIENT INFORMATION:

Name: _____ ☐ M ☐ F
Last First MI

Home Phone: (____)_____ Work: (____)_____ Cell: (____)_____

Date of Birth: _____/_____/_____ Age _____ Marital Status: _____

SS# _____ Drivers License # _____

Address: _____
Street # Street Name Apt. #

_____
City State Zip

Employer: _____ Occupation: _____

Referred by (name): _____ Family Physician: _____

MEDICATION ALLERGIES: _____

Nearest friend not living with you: _____(____)_____
Name Phone number

Emergency Contact Information:
In case of emergency, who should we notify? _____
Relationship to patient: _____ Phone: (____)_____

INSURANCE INFORMATION: Do you have insurance? ☐ Yes ☐ No

Primary Insurance Carrier: _____ ID #_____

Deductible: _____ Office Visit Co-Pay: _____
(You can obtain the above information by calling the toll free number on your insurance card)

Policy Holder: _____ GROUP # _____

Secondary Insurance Carrier: _____ ID#_____

Policy Holder: _____ GROUP # _____

What is the best way to contact you with test results: ☐ Home Phone ☐ Work Phone ☐ Cell Phone
May we leave a message on your answering machine or voicemail? ☐ Yes ☐ No
May we leave a message regarding your personal medical information with a family member?
☐ Yes - Name of family member: _____ Phone: (____)_____ ☐ No
May we contact you by e-mail? ☐ Yes - email address _____ ☐ No

OFFICE POLICY

Payment is your responsibility regardless of insurance coverage. Any services/charges that are considered to be cosmetic or not medically necessary will be the patient's responsibility. We will process claims for insurance carriers our doctors are contracted with after copays and deductibles have been met. For those with dual PPO coverage, we follow the guidelines of the primary contract only. **PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR ALL OTHER PATIENTS.** I have read and understand the above statements. I agree to comply with the financial policies stated.

Signature: _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

The undersigned hereby authorizes Bernardo Dermatology, its associated doctors and agents to release and/or furnish information concerning my past and present medical history and condition to those doctors that I may designate or referred to either now, or from time to time in the future. This information may be used for diagnosis, treatments, consultations, and all medical purposes consistent therewith. This authorization will remain in effect unless terminated in writing.

Signature: _____ Date _____

Name_____ Date_____

Please Answer These Questions And Return This Page To The Receptionist

Thank You Please Circle the Correct Answers

1. Allergies to Drugs or Medicines **No** **Yes_(list)**_____

_____

2. Allergies to Other Things No Yes_(list)_____

_____

3. Are You Taking Medication Now **No** **Yes_(list)**_____

_____

Is there Any Pesonal History of: *(you)*			Family History of *(blood relatives only)*		
4.	**Hayfever**	**Yes No**	**Hayfever**	**Yes**	**No**
5.	Asthma	Yes No	Asthma	Yes	No
6.	**Eczema**	**Yes No**	**Eczema**	**Yes**	**No**
7.	Psoriasis	Yes No	Psoriasis	Yes	No
8.	**Skin Cancer**	**Yes No**	**Skin Cancer**	**Yes**	**No**

If any question on this page reveals information which is private or priviledged in any way please skip the question and feel free to discuss it with the doctor in person.

9.	Diabetes	Yes No	Diabetes	Yes	No
10.	**Gout**	**Yes No**			
11.	Heart Attack	Yes No	Heart Attack	Yes	No
12.	**Stroke**	**Yes No**			
13.	Abnormal Heart Beat	Yes No			
14.	**Blood Clots**	**Yes No**			
15.	High Blood Press	Yes No			
16.	**Bleeding Problems**	**Yes No**			
17.	Gall Bladder Prob.	Yes No			
18.	**Kidney Disease**	**Yes No**			
19.	Stomach Ulcers	Yes No			
20.	**Prostate Trouble (men)**	**Yes No**			
21.	Cataracts	Yes No			
22.	**Hepatitis**	**Yes No**	**Hepatitis**	**Yes**	**No**
23.	Anemia	Yes No			
24.	**Breast Cancer**	**Yes No**			

25. Have You Ever Had a Blood Transfusion?
Yes No When (year) _____

26. Are you or any member of your family HIV postitve? _____

27. Do you belong to any known high risk group for developing HIV? _____
HIV testing is available through this office.

28. Approximately When was your last Electrocardiogram? _____

29. Are You Pregnant? Yes No Not Sure

30. Do You Smoke? Yes No

31. Do You Take Aspirin Daily As Needed Rarely Never

32. Are you being seen by your doctor for any on going medical conditions other than those listed above? If so, please describe _____

_____

Thank You

Bernardo Dermatology Medical Group, Inc.

To Our Patients:

Welcome to our office! We hope you will find your care here pleasant and thorough.

In order to provide you with a complete evaluation, an all over full body skin examination is important and often vital to your care, particularly given the rising incidence of skin cancer. As part of your initial visit, and at no extra charge, we would like to examine both exposed and unexposed areas of your skin for which the nurse will request that you undress. If you strongly prefer otherwise, please let us know.

❑ Agree

❑ Disagree

Thank you.

Ruth A. Larson, M.D.
Francis A. Barber, Jr., M.D.
Elizabeth E. Vierra, M.D.
Mark A. Vierra, M.D.
Lynn P. Shipman, M.D.
Vanessa London, M.D.
Leah Brown, N.P.

_____
Patient Name

_____
Date

15525 Pomerado Road, Suite A-2, Poway, CA 92064 (858) 451-3311 • Fax (858) 451-1142

BERNARDO DERMATOLOGY MEDICAL GROUP

HIPAA PRIVACY POLICY

Dear Patient:

We are committed to respecting your privacy and your confidential health information. However, in order to provide excellent care, it is sometimes necessary to share your health information with doctors or other health care providers who are involved in your care. In order to do so, we need your consent.

It is also necessary to share your health information with your health insurance company or its agents, in order to obtain payment for our services. Once again, we need your consent before we will release such information. If you do not wish to provide this consent, then we will set up your account on a "cash basis" and it will be your responsibility to pay for services at the time rendered.

Thank you.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO DOCTORS OR OTHER HEALTH CARE PROVIDERS

I hereby authorize Bernardo Dermatology to disclose protected health information to my doctors, their office staffs, and hospitals in which I am a patient in the emergency room or in which I am admitted as a patient. I understand that such information will be disclosed for the purpose of medical care and treatment only.

Dated: _____ Signature: _____

AUTHORIZATION FOR BILLING INSURANCE OF OTHER THIRD PARTY

I hereby authorize Bernardo Dermatology to disclose protected health information to my health insurance company or other third party payor for the purpose of paying for medical services rendered.

Dated: _____ Signature: _____

******<u>Only sign below if you DO NOT agree to the HIPAA Privacy Policy</u> ******

AGREEMENT TO PAY AT TIME OF SERVICES

I do NOT authorize Bernardo Dermatology to disclose protected health information to my health insurance company or other third party payor. As a result, I understand that Bernardo Dermatology will NOT bill my insurance or other third party. I will pay for services at the time that they are rendered.

Dated: _____ Signature: _____

Bernardo Dermatology Medical Group, Inc.

To Our Patients:

As any of you who have checked into a hotel lately know, you are asked for a credit card at the time of check in. This is an advantage for both you and the hotel, since it makes checkout faster and more efficient. We are going to implement a similar policy.

You will be asked for a credit card at the time you check in and the information will be held securely until your insurances have paid and made their determination of the amount of your co-pay. At that time any remaining balance owed by you will be charged to your credit card, and a copy of this will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out.

This in no way will compromise your ability to dispute a charge or an insurance company's determination of payment.

Co-pays due at the time of the visit will still be due at the time of the visit.

Sincerely yours,

Bernardo Dermatology Medical Group, Inc.

Ruth Larson, M.D.	Elizabeth Vierra, M.D.
Mark Vierra, M.D.	Francis A. Barber Jr, M.D.
Lynn P. Shipman, M.D.	Vanessa A. London, M.D.
Julie A. Gladsjo, M.D., Ph.D.	

I authorize Bernardo Dermatology Medical Group, Inc. to charge outstanding balances on my account to the following credit card:

Card _____Account number _____exp. _____

Name (please print) _____

Signature _____ Date _____

15525 Pomerado Road, Suite A-2, Poway, CA 92064 (858) 451-3311 FAX: (858) 451-1142
Website www.bernardoderm.com