421 N. Rodeo Dr.
Terrace Level, North (2nd Floor) T-7
Beverly Hills, CA 90210
310-274-5372

MOY :: FINCHER :: CHIPPS
FACIAL PLASTICS & DERMATOLOGY

PATIENT REGISTRATION

Patient Information

Name:_____ ☐ Jr. ☐ Sr.
Last First Middle
Prefer to be called:_____ Title: ☐ Mr. ☐ Mrs. ☐ Miss

Date of Birth: ____/_____/_____ Age:____ Sex: ☐ Male ☐ Female Marital Status:_____

Address:_____
Street Number Street Name City State Zip Code

Preferred? ☐Home Phone: _____☐ Cell Phone: _____☐ Work Phone:_____

Email: _____ Social Security: _____-_____-_____

Employer:_____
Name Address Phone
Occupation:_____Hobbies:_____

Who referred you: _____ Primary Care Physician:_____

Pharmacy of Choice:_____ - _____
Pharmacy Name Pharmacy Zip Code
Emergency Contact: _____ Phone: _____

Do we have your permission to:
☐ Send you electronic communication
☐ Leave a message on your answering machine at home
☐ Leave your message at your place of employment
☐ Discuss your medical condition with any member of your household.
If yes, whom:_____ Relationship:_____

Responsible Party/Parent (if different from patient)

Name:_____ ☐ Jr. ☐ Sr.
Last First Middle
Date of Birth: ____/_____/_____ Age:____ Sex: ☐ M ☐ F Social Security: _____-____-_____

Address:_____
Street Number Street Name City State Zip Code

Preferred? ☐Home Phone: _____☐ Cell Phone: _____☐ Work Phone:_____

Reason for Visit.
Please describe what the problem is, where it is located, how it bothers you, when it first began, what is first looked like, what you think caused it, was a biopsy done, and any other treatments you have had so far.

_____
_____
_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician**. I also approve all of the above information.**

Patient or Responsible Party Signature:

_____ Date: _____

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MEDICAL HISTORY

Check all that apply. Height: _____ Weight: _____

General Medical History:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory Bowel Disease
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Migraines
- ☐ Organ Transplant
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ I am over 65 and have received the pneumonia vaccine since turning 65.
- ☐ I wear contacts, glasses, and/or dentures. Specify which: _____
- ☐ None/Other: _____

Past Surgeries:

- ☐ Appendix: Appendectomy
- ☐ Bladder: Cystectomy
- ☐ Breast: Biopsy
- ☐ Breast: Implants
- ☐ Colon: Resection
- ☐ Cosmetic: Type _____
- ☐ Gallbladder: Cholecystectomy
- ☐ Heart: Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Transplant
- ☐ Heart: Pacemaker
- ☐ Joint Replacement: Hip
- ☐ Joint Replacement: Knee
- ☐ Kidney: Nephrectomy
- ☐ Liposuction
- ☐ Liver Transplant
- ☐ Liver Shunt
- ☐ Ovaries: Endometriosis
- ☐ Ovaries: Oophorectomy
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Cancer
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Spleen: Splenectomy
- ☐ Testicles: Orchiectomy
- ☐ Uterus: Hysterectomy
- ☐ None/Other: _____

Skin Type: If in the sun without sunscreen, would you:

- ☐ 1. Always burn, never tan
- ☐ 2. Always burn, sometimes tan
- ☐ 3: Sometimes burn, always tan gradually
- ☐ 4. Burn minimally, always tan well
- ☐ 5. Rarely burn, tan profusely
- ☐ 6. Never burn, deeply pigmented

Skin History:

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Atypical Moles
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Squamous Cell Skin Cancer
- ☐ I wear sunscreen. SPF: ___
- ☐ I tan in tanning salon
- ☐ None/Other: _____

Family History:

☐ Melanoma ☐ Basal/Squamous Cell Carcinoma

If yes, which relative: _____

Social History:

- ☐ I am pregnant and/or breastfeeding
- ☐ I am contemplating pregnancy

Sexual History
- ☐ Not sexually active
- ☐ Active with one partner
- ☐ Sexually active with more than one partner
- ☐ Sexually active with same gender partner

Cigarette Smoking
- ☐ Never smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily

Alcohol Use
- ☐ None
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks d day
- ☐ 3+ drinks a day

Safety
- ☐ Feel safe at home

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MEDICATION/ALLERGY LIST

Medications: ☐ No current medications

Name	Dosage	How Often

Allergies: ☐ No known/current allergies or medication sensitives

Medication/Food	Reaction

PHOTOGRAPHY CONSENT

Photography Consent

I consent to and authorize Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., or Lisa Chipps , M.D., and his/her associates to take photographs of parts of my body (and/or pathology images) in connection with the dermatologic procedures (surgical or non-surgical) performed by Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., or Lisa Chipps , M.D., and his/her associates.

I understand that such photographs are used by Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., or Lisa Chipps , M.D., and his/her associates in order to monitor the results of your treatment(s).
I understand that such photographs may be published by Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., or Lisa Chipps , M.D., and his/her associates in any print, visual, or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about dermatologic surgery methods.

This may include:

1. Patient Education- (showing patients my before and after photographs)
2. Advertisements- (showing before and after photographs)
3. Displays in the office- (showing before and after photographs)
4. Scientific/ Medical publications, presentations, and classes
5. Books, magazines, and other presentations

If there are any objections to any of the above items mentioned, please cross off the line and place your initials adjacent to the crossed off area.

Neither I, nor any member of my family will be identified by name in amy publication. I understand that, although an attempt will be made to hide my identity, in some circumstances the photographs may portray features which could make my identity recognizable.

I release and discharge Ronald Moy, M.D., Edgar Fincher, M.D., Ph.D., or Lisa Chipps , M.D., and his/her associates, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature:

_____ Date:_____

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PATIENT RIGHTS AND RESPONSIBILITIES

List Of Patient Rights:

In accordance with health and safety codes, the asc and medical staff have adopted the following list of patient rights:

1. Our Surgery Center does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment, or the source of payment for his or her care.
2. Considerate and respectful care and the right to exercise his or her rights without discrimination or reprisal and be free from all forms of abuse or harassment.
3. Knowledge of the name of the physician who has primary responsibility for coordinating his or her care and the names and professional relationships of other physicians who will see the patient.
4. Receives information from his or her physician about his or her illness, his or her course of treatment and his or her prospects for recovery in easily understood terminology.
5. Receives as much information about any proposed treatment or procedure as he or she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved and knowledge of the person who will carry out the procedure or treatment.
6. Participates actively in decisions regarding his or her medical care, to the extent permitted by law, including the right to refuse treatment.
7. Receives full consideration of privacy concerning his or her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to know the reason for the presence of any individual.
8. Is given confidential treatment of all communications and records pertaining to his or her care and his or her stay in the ASC. His or her written permission shall be obtained before his or her medical records can be made available to anyone not directly concerned with his or her care.
9. Receives reasonable responses to reasonable requests he or she may make for services.
10. He or she may leave the ASC, even against the advice of his or her physicians.
11. Receives reasonable continuity of care and advance knowledge of the time and appointment location, as well as knowledge of the physician providing the care.
12. Is advised if ASC/personal physician proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in any research projects.
13. Will be informed by his or her physician, or a delegate of his or her physician, of his or her continuing health care requirements following his or her discharge from the Surgery Center.
14. May choose a different physician than was assigned to that patient.
15. Is made aware that this facility does not honor Advance Directives.

Patient Responsibilities

1. To work with your healthcare team and to follow all safety rules.
2. To show respect and consideration to our staff and to other patients and visitors.
3. To respect the privacy of other patients.
4. To give your healthcare team complete and correct information about your health.
5. To tell your doctor about any changes in your health after you leave our facility.
6. To keep, or cancel in a timely manner, your scheduled appointments for your health care.
7. To follow the directions given by your healthcare team after you have agreed to treatment in our facility.
8. To tell your healthcare team if you wish to change any of your decisions.
9. To ask for clarification if you do not understand any information or instructions given to you by your healthcare team.
10. To inform his/her provider about any living will, medical power of attorney, or other directive that could affect his/her care.

Surgery Center Disclosure Of Ownership: The owners of the Moy-Fincher-Chipps Surgery Center are Ronald L. Moy, M.D., Edgar F. Fincher, M.D., PhD, and Lisa Chipps, M.D.

For complaints or comments about your medical care, you may contact our administrator or Medical Director at 310-274-5372 or you may then contact the: CDPH, California Department of Public Health, Division of Health Facilities, 3400 Aerojet Ave- Suite 323, El Monte, CA 91731; Or you may contact AAAHC, 5260 Old Orchard Rd. - Ste. 200, Skokie, IL 60077. You may also contact the Office of the Medicare Beneficiary Ombudsman at:www.medicare.gov/Ombudsman/resources.asp

I have read and understand all of the above information.

Patient or Responsible Party Signature:

_____ Date:_____

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BILLING POLICIES

Office Policy for Insurance Billing

Moy-Fincher-Chipps Facial Plastic/Dermatology is enrolled in numerous insurance programs to accommodate the needs of our patients.

With each insurance program, there are many individual requirements of the plans, having different stipulations regarding what services are covered and how often they may be performed. These plans differ depending on what type of contract you've selected with the insurance carrier.

Because we do not have access to your guidelines and stipulations, we must rely on you, the patient, to inform us each time of services exactly what those guidelines and stipulations are, especially if you need plastic or reconstructive surgery in our ambulatory surgical center (ASC).

Unfortunately, if you do not inform us of special recruitments in your insurance contract such as lab work, biopsies, ASC and/or out-patient referral from your primary care physician, we have no choice but to bill you directly for those charges. Payment for those charges is then your responsibility.

At the time of service we will collect your 20% co-insurance and/or any outstanding deductible.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of the office. Payment is required for all services at the time they are rendered. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. IN the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account.

I have read and understand the office policy stated above and agree to accept responsibility as described.

Patient or Responsible Party Signature:

_____ Date:_____

No Show & Cancellation Bolling Policy

The Moy-Fincher-Chipps Medical Group will collect Account Balances, Co-Pays, Co-Insurance, & Deductible Amounts at the time of service.

No show and Late Cancellation Fees (That is, cancellation without 24 hours of notice), will also be collected. The fees are as follows: $30 for a follow up appointment, $65 for new patients and cosmetic visits. All balances that remain outstanding for more than 30 days will accrue a 10% account fee.

Thank you for your understanding and compliance with our office policies.

Sincerely, The doctors of the Moy-Fincher-Chipps Medical Group

I, _____,have been informed of these policies.
Patient's Name

Patient or Responsible Party Signature:

_____ Date:_____

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OPTIONAL AUTHORIZATION

Due to changes in healthcare that have decreased physician reimbursements and increased the clerical and administrative work required to secure payment for medical services rendered, the Moy-Fincher-Chipps Medical Group must change its billing policy for the collection of copayments and payment balances, effective October 01, 2009.

The Moy-Fincher-Chipps Medical Group will no longer send invoices to patients for balances or copayments. **We ask for a credit card to be kept on file; it is optional to provide it to us.**

When the Explanation of Benefits (EOB) paperwork is received from your insurance company, which indicates the amount that the patient is responsible for (i.e. co-payment, deductibles, etc.), your credit card will be directly charged for those fees. You will ONLY be charged for amounts that your insurance company has determined to be the patient's responsibility.

Another option is for the patient to pay for services rendered at the time of visit by cash, check, or credit card. If and when the insurance company makes its payment to us, a reimbursement will be forwarded to you in a prompt manner.

As a courtesy to our patients, we will continue to bill insurance companies for services provided by our doctors.

Thank you for your understanding and compliance with our office policies.

Sincerely,
The Doctors of the Moy-Fincher-Chipps Medical Group

Authorization To Charge Credit Card

Patient Name:_____

I have read the above policy and authorize the Moy-Fincher-Chipps Medical Group to keep my signature on file and to charge my credit card for the balance of charges to my account (deductibles, co-payments, and non-covered services) NOT paid by my insurance.

Credit card type: VISA MC AMEX Other:_____

Credit Card Number:_____ 3 digit security code:_____

Printed Name on card:_____ Expiration Date:_____/_____

Cardholder's Signature:_____ Date:_____