PLEASE CHECK ONE:
- ☐ Gary R. Carlson, M.D.
- ☐ Randolph S. Capri, M.D.
- ☐ Michael R. Bastien, M.D.
- ☐ Thomas J. Kim, M.D.
- ☐ Holly L. Rausch, M.D.
- ☐ Judith S. Feldman, M.D.

DERMATOLOGY ASSOCIATES OF WESTLAKE/MALIBU

Patient Information

Today's Date _____

Patient's Name _____
LAST FIRST INITIAL

☐ Male ☐ Female Age _____ DOB: / / Marital Status ☐ S ☐ M ☐ W ☐ DIV

Social Security No. _____ Driver's Lic. # _____

Cell Phone _____ Home Phone _____

Address _____ City & State _____ Zip _____

Employers Name _____ Occupation _____

Employer's Address _____ City & State _____ Zip _____ Phone _____

Spouse or
Parent Name _____ Occupation _____

Spouse or
Parent Address _____ City & State _____ Zip _____ Phone _____

Spouse or
Parent Employers Name _____

Address _____ City & State _____ Zip _____ Phone _____

Emergency Contact _____ Phone _____

Address _____ City & State _____ Zip _____

Who Referred You _____ Email: _____

Please complete section below if patient is a minor

Mr.
Mrs.
Ms. _____
NAME STREET ADDRESS (NOT P.O. BOX) CITY STATE ZIP PHONE

_____
EMPLOYER STREET ADDRESS CITY STATE ZIP PHONE

Social Security No. _____ Driver's Lic. # _____

INSURANCE INFORMATION: indicate which insurance is primary (1) and secondary (2).

_____
(1) NAME OF INSURANCE COMPANY SUBSCRIBER (POLICY HOLDER) SUBSCRIBER (Date of Birth)

_____
(2) NAME OF INSURANCE COMPANY SUBSCRIBER (POLICY HOLDER) SUBSCRIBER (Date of Birth)

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:
I, the undersigned, authorize payment of medical benefits to DERMATOLOGY ASSOCIATES for any services furnished to me by the physician. I understand I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

ANY PERSONAL BALANCE 60 DAYS OR MORE PAST DUE WILL BE SUBJECT TO A 18% FINANCE CHARGE.

Date: _____ Signed _____

MEMBER SIGNATURE ON FILE: (SEE REVERSE)

MEDICARE "SIGNATURE ON FILE" REQUIREMENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to DERMATOLOGY ASSOCIATES for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its' agents any information needed to determine these benefits of the benefits payable to related services.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer of the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Signature

MEDICARE PATIENTS

Are you currently employed? Full Time____ Part Time____	Y	N
If yes, do you have medical insurance under an employer?	Y	N
Name of insurance: _____		
Is your spousse currently employed?	Y	N
If yes, do you medical insurance through spouse's employer?	Y	N
Name of insurance: _____		
Do you have group health plan coverage based on your own, or a spouse's current employment	Y	N

DERMATOLOGY ASSOCIATES

WESTLAKE VILLAGE • MALIBU

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

For the convenience of our patients, our NOTICE OF PRIVACY PRACTICES is available in our reception area for review. Please feel free to take a copy with you at any time. A copy is also available at our web site for your review.

i hereby acknowledge that I have been offered a copy of this medical office's NOTICE OF PRIVACY PRACTICES. I further acknowledge that a copy of the current notice is posted in the reception area of this medical office. If amended, I will be provided with a copy of the amended NOTICE OF PRIVACY PRACTICES upon request and that copies of the amended notice will be posted in the reception area updating the original.

I understand that I can refuse to sign this acknowledgement if I so choose.

Signed:_____ Print Name:_____

Date:_____ Telephone:_____

If not signed by the patient, please indicate below:

_____Parent/ guardian of patient

Name of Patient: _____

OFFICE USE ONLY

_____

Witness

PROTECTED HEALTH INFORMATION (PHI) DISCLOSURE RECORD

Authorized Methods of Communication (check all that apply)

Cell Number	Home Telephone	Work Telephone
Number ( )	Number ( )	Number ( )
❑ Leave call back number only: do not leave message	❑ Leave call back number only: do not leave message	❑ Leave call back number only: do not leave message
❑ Okay to leave detailed message with family member	❑ Okay to leave detailed message with family member	❑ Okay to leave detailed message with family member
❑ Okay to leave detail message on voicemail	❑ Okay to leave detail message on voicemail	❑ Okay to leave detail message on voicemail

Patient Signature: _____ Date: _____

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Holly L. Rausch, M.D.

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