Bita Bagheri, MD

General Information

Patient information _____
Last First Middle

Home Address _____
City State Zip Code

Home Phone (___)_____Cell Phone (___)_____Birthday ____/_____/_____

Age:_____ Genetic Sex: M / F Gender Identity M / F (circle one) Employed, unemployed, student

E-Mail Address: _____

Spouse / Parent _____Who referred you to this office_____

Emergency Contact Name & Phone number_____

Medical Information

Primary Doctor: Name: _____

Phone: _____ Fax: _____

Pharmacy name: _____Phone: (____)_____ Fax: (____)_____

_____
Address City State Zip Code

List all of your Medical Conditions (or write *NOT* applicable)

_____

_____

List any Surgeries you have had and the dates performed (or write *N/A)*

1. _____Date: _____/_____/_____
2. _____Date: _____/_____/_____
3. _____Date: _____/_____/_____
4. _____Date: _____/_____/_____

Y N Personal history of Melanoma? If yes, please indicate where on your body: _____

Y N History of skin Cancer? If yes, please indicate where on your body: _____

Y N History of Basal Cell Carcinoma? If yes, please indicate where on your body: _____

Y N History of Squamous Cell Carcinoma? If yes, please indicate where on your body: _____

Y N Unknown type? If yes, please indicate where on your body: _____

Y N Does your family have a history of malignant melanoma? If yes, who? _____

Y N Have you ever had moles removed that were described as atypical? If yes, please describe location and how long ago were they removed?

_____

Y N Do you have a history of other dermatologic conditions? If yes, please list below

1. _____3. _____

2. _____ 4.. _____

Y N Use sunscreen regularly. Y N Use tanning beds ? Previously or currently Y N Use sunscreen regularly
Y N Blood Thinners? Y N Use sunscreen regularly

List all of your medications (or write *NOT* applicable) Please use a separate piece of paper if more than the space provided

Name of Medication	prescription	Non prescription	Regular / Occasional	Dose	Frequency

Allergies to medications or painkillers: Yes / No if Yes, please List:

1._____ 2. _____3. _____

Type of reaction (Example Rash, Anaphylaxis):

1._____ 2. _____3. _____

Allergy to (please circle): Adhesives Yes / No Latex Yes / No Lidocaine Yes / No

Smoker: Yes / No How much: _____ Alcohol: Yes / No How much:_____

Please write the reason for your visit_____

How long has your symptoms / Condition been present? _____

Have you had this condition before? If so, when? _____

What areas are affected? _____

Please describe your symptoms, if any _____

Does anything make your symptoms better or worse? _____

Is this condition causing: (please circle Y for yes N for No)

Weight Loss Y N Fever Y N Is this condition affecting your general health? Y N

If yes, please explain_____
_____

Consent to treatment

I give my consent for evaluation and management of my medical and / or cosmetic conditions(s) : This may require procedures with or without another Bita Bagheri M.D. staff member present. Management of certain derma logical conditions may require procedures such as biopsies, injections, excisions, cryotherapy, etc. Al procedures will be discussed by your provider

Signature of patient _____Date: _____/_____/_____

Digital photo consent

Photographs are used to monitor progression of disease and effectiveness of treatments. Photographs are frequently taken before, during and after medical and cosmetic procedures and are considered part of your medical record. Any photos taken of you will be kept with Bita Bagheri, M.D in accordance with our privacy practices.

Signature of patient _____Date: _____/_____/_____

Acknowledgement of receipt of notice of privacy practices

We are required by law to notify you of how medical information about may be used and disclosed by Bita Bagheri, M.D and how you can get access to this information. By signing below, you acknowledge that (1) you are the patient or the patient's responsible party () you received a copy of "*notice of privacy practices"* and (3) you understand that you may contact the practice manager if you have any questions about the notice

Signature of patient _____ Date: _____/_____/_____

Expanded authorization to disclose protected health information

If you authorize employees to leave a voicemail with protected health information (e.g biopsy results, blood work results, culture results etc.) indicate phone number(s) associated with the authorized voicemail box(s) and sign below
Phone Number 1. _____Phone number 2. _____

Signature of patient or responsible party _____Date: _____/_____/_____
If you authorize employee' to leave protected health information (e.g biopsy results, blood work results, culture results, etc) with another individual (e.g spouse, parent, sibling, significant other, etc) please sign below and complete appropriate fields

Name of authorized individual _____Relationship to patient _____

Phone number (_____)_____Signature of patient or responsible party_____
Date: _____/_____/_____

Cancellation / NO Show policy for Physician office visit

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing anther patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not canceled at least 24 hours in advance you will be charged a seventy-five-dollar ($75.00) fee; this will not be covered by your insurance company.

Cancellation / NO Show policy for cosmetic and in-office procedures

If an appointment is not canceled at least 48 hours in advance you will be charged a hundred-dollar ($100.00) fee; this fee will not be covered by your insurance company.

Print Name: _____
First Last

Signature of patient / Guardian: _____Date: _____/_____/_____

HEALTHCARE ELIGIBILITY WAIVER

Patient Name _____ Health Plan _____

The Patient or Patient's Legal Representative hereby certifies that he/ she is eligible for health benefits coverage, and has chosen the above stated physician as the provider of his/ her healthcare.
Furthermore, the Patient or Patient's Legal Representative understands that if he/ she is found ineligible for coverage of plan benefits, he/ she is financially responsible for all costs incurred during the delivery of health services, and agrees to pay these charged to the physician accordingly.

_____ _____

Print Name Signature

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS

I hereby authorize Bita Bagheri M.D. to obtain any and all medical records concerning my care from any physician, hospital or other health care professionals that have provided care to me at any time. Additionally, I authorize Dr Bita Bagheri to release any and all medical records concerning my care to any insurance company, third party.

Name:_____
Last First Middle

Home Phone (___)_____

Date of Birth_____/_____/_____

Patient Signature _____

Date _____/_____/_____

Authorization to release medical information (Other individuals)

I hereby authorize Bita Bagheri M.D. to release any and all medical records concerning my care to the following individual (s).

Name:_____ _____
Last First Middle

Address _____
City State Zip Code

Home Phone (___)_____Cell Phone (___)_____

Name:_____ _____
Last First Middle

Address _____
City State Zip Code

Home Phone (___)_____Cell Phone (___)_____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical service(s)

_____Patient's or Patient Representative's Initials Date: _____ / ___/____

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this arbitration agreement.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ By:_____

Patient or Authorized Representative's Signature Physician's or Authorized Representative's Signature

(If Representative, Print Name and Relationship to Patient) _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. OUR USES AND DISCLOSURES We typically use or share your health information in the following ways. To manage your care: We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition. To run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services. To bill for your services: We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services. To help with public health and safety issues: We can share health information about you for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety, etc. To do research: We can use or share your information for health research. To comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. To respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations. To work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies. To address workers' compensation, law enforcement, and other government requests: We can use or share health information about you for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services, etc. To respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena. How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information. Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated: You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by law to notify you of how medical information about you may be used and disclosed by Dr. Bita Bagheri, M.D and how you can get access to this information. By signing below, you acknowledge that: (1) you are the patient or the patient's responsible party; (2) you received a copy of the "Notice of Privacy Practices"; and, (3) you understand that you may contact the practice manager if you have questions about the notice.

Signature of Patient or Responsible Party _____Date _____/ ____/ _____

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request

EXPANDED AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

If you authorize employees to leave a voicemail with protected health information (e.g. biopsy results, blood work results, culture results, etc.), indicate the phone number(s) associated with the authorized voicemail box(s) and sign below.

Phone Number 1 _____Phone Number 2 _____

Signature of Patient or Responsible Party _____ Date _____/ ____/ _____

If you authorize employees to leave protected health information (e.g. biopsy results, blood work results, culture results, etc.) with another individual (e.g. spouse, parent, sibling, significant other, etc.), please sign below and complete the appropriate fields.

Name of Authorized Individual _____Relationship to Patient _____

Phone Number _____Signature of Patient or Responsible Party _____

Date _____/ ____/ _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing Dr. Bita Bagheri, M.D for your care. We require every patient to read and sign the following agreement before provision of care. We are happy to answer questions about this policy. If you refuse to sign this agreement, services will not be provided. If you do not have health insurance or if our practice is not contracted with your insurance plan, you will be required to pay all charges, in full, at the time of service. Should you have health insurance, it is your responsibility to provide us with complete, accurate, and up-to-date information in order for us to successfully bill your insurance company. It is also your responsibility to obtain any authorization or precertification required for insurance coverage before services are rendered. It is your responsibility to understand your benefits. We encourage you to contact your health plan member services representative with questions about coverage, pre-authorization or precertification requirements and to ensure that such requirements were met, prior to receiving services from us. Ultimately, you are responsible for any charges incurred which were not authorized or certified by your health plan. You understand and agree that it is your responsibility to pay applicable deductible, co-payments, co-insurance, and / or outstanding balances at the time of service. You authorize payment directly to Dr. Bita Bagheri, M.D ior medical insurance benefits payable under the terms of your policy. If, for any reason, your health insurance does not pay for services rendered you understand that you are responsible for all charges and, by signing below, agree to pay upon receipt of an invoice issued by our practice, or from third party laboratories and/or pathologists. I understand that this policy will not change based on date of service, type of service, health plan or change of health plan coverage. I have read the policy and fully understand my responsibilities and obligations.

Patient Name (Print) _____
Last First Middle

Responsible Party Name (Print) _____
Last First Middle

Responsible Party Signature_____Date _____ /____ /_____