HAROLD LANCER, MD. F.A.A.D.

DIPLOMATE, AMERICAN BOARD OF DERMATOLOGY

ASSISTANT CLINICAL PROFESSOR, UCLA SCHOOL OF MEDICINE

A MEDICAL CORPORATION
440 N. RODEO DRIVE
BEVERLY HILLS, CA 90210
TELEPHONE (310) 278-8444 FAX (310) 278-7626

Name: ____
Last Name First Middle Initial

Date of Birth: __________ Age: _____ Sex: _____ SS#: ______________ DL#: _______________

Home Address: ____

Cell #: ___________________ Home#: ___________________ Work#: ______________________

Email Address: _________________________________@__________________________________

Occupation: ___________________ Work address: ______________________________________

Nearest Relative Living with You: _________________________ Phone#: __________________
(Or nearest not living with you, if above does not apply)

Whom we may contact, in an emergency? ____

Day Phone: _____________________________ Night Phone: _____________________________

Primary Physician: _____________________________ Phone: _____________________________

Whom We May Thank for Referring You to Us? ____

Primary Method of Payment: Check ______ Cash ______ Credit Card ______

FINANCIAL POLICY

We are committed to providing you with the best possible care. However, payment is due at the time services were rendered. We accept cash and credit cards. Returned checks and balances older than 90 days may be subject to additional collection fees for which you are responsible.

As a courtesy, we will respond to any of your insurance requests after you have submitted your bill. We must emphasize however, that as medical care providers, our relationship is with you and not your insurance company. I also authorize your office to release medical records for insurance reimbursement I have read all the information on this sheet.

I understand and agree that I am financially responsible for the balance on my account for any services rendered. I have completed the above questions and certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in health status or the above stated information.

Signed: _____________________________ Date: __________Checked in by: __________________

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HEALTH AND MEDICAL HISTORY

ETHNICITY

☐ Asian ☐ African American ☐ North African ☐ Middle Eastern ☐ Celtic
☐ Northern European ☐ Southern European ☐ Native American ☐ Latin

1. Are you sensitive or ALLERGIC to any drugs /medications? Yes / No
   If yes, please list: ______________________________
2. Have you had any excessive bleeding requiring medical treatment? Yes / No
   If Yes, please list: ______________________________
3. Are you under the care of a dermatologist? Yes / No
   If Yes, please list: ______________________________
4. Are you under the care of a Physician (including family doctor and PCP's) Yes / No
   If Yes, please list: ______________________________
5. Are you using any drugs or medications? Yes / No
   If Yes, please list: ______________________________
6. Are you currently having Facials? Yes / No
   If Yes, please list: ______________________________
7. Have there been any changes in your General Health within the past year? Yes / No
   If Yes, please list: ______________________________
8. Have you ever had Heart Surgery, MVP or Heart Ailments? Yes / No
   If Yes, please list: ______________________________
9. Have you ever had any serious Illness, Surgery or Hospitalization? Yes / No
   If Yes, explain the reason and the admission date ______________________
10. Date of your last Physical Exam? ______________________
11. Women: Are you Pregnant or Nursing? Yes / No
    If Yes, please list which is applicable and number of months: ________________
12. Do you smoke tobacco now, or in the past? Yes / No
    If Yes, how long? ______________________________
13. Do you wear Glasses or Contact Lenses? Yes / No
    If Yes, please list which is applicable and how often: ______________________
14. Do you have or have had any of the following?
    ( ) Anxiety
    ( ) Artificial Joints
    ( ) Asthma or Hay Fever
    ( ) Blood Disease
    ( ) Cold Sores or Herpes
    ( ) Depression
    ( ) Diabetes
    ( ) Epilepsy
    ( ) Excessive Bleeding
    ( ) Eye Trouble
    ( ) Fainting Spells or Seizures
    ( ) Frequent or severe headaches
    ( ) Hepatitis, Jaundice, Liver Disease
    ( ) Kidney Disease
    ( ) Radiation Treatment of any kind
    ( ) Respiratory Disease
    ( ) Rheumatic Disease
    ( ) Skin Diseases
    ( ) Stroke
    ( ) Tumors
    ( ) Venereal Diseases
15. Do you have a disease or condition not indicated above which you feel we should know about?
    Please explain: ____

____

I hereby authorize Harold Lancer, M.D., to take study models, photographs, or any other diagnostic aid, deemed appropriate by Harold Lancer, MD.

Signed: ______________________________ Date: ________________

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices by email at: ______________________________

Signed: ______________________ Date: ______________________

Print Name: ______________________ Telephone: ______________________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient
☐ Guardian or conservator of an incompetent patient
☐ Beneficiary or personal representative of deceased patient

Name of Patient: ______________________________

For Office Use Only:

☐ Signed form received by: ______________________________

☐ Acknowledgement refused:

Efforts to obtain:

____

____

Reasons for refusal:

____

____

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NOTICE OF PRIVACY PRACTICES

I. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

II. We have a legal duty to safeguard your protected health information (PHI). We are legally required to protect the privacy of your health information We call this information protected health information, or PHI for short, and it includes information that can be used to identify you that we've created or received about your past, present , or future health or condition, the provision of health care to you, or the payment of this health care, We must provide you with this notice about our privacy practices that explains how, when and why we sue and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI that is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.
However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice on our Web site at www.r-p-m.com.

III. How we may use and disclose your protected health information.
We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations. We may use and disclose our PHI for the following reasons:

1) For Treatment: We may disclose your PHI to physicians, nurses, medical students and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical rehabilitation facility in order to coordinate your care.
2) To obtain payment for treatment. We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and other that process our health care claims.
3) For healthcare operations. We may disclose your PHI in order to operate this facility. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professional who provided health care services to you. We may also provide your PHI to our accountants, attorney, consultants and other in order to make sure we are complying with the laws that affect us.

B. Certain Uses and Disclosures Do Not Require Your Authorization. We may use and disclose your PHI without your authorization for the following reasons:

1) When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement. For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victim of abuse, neglect or domestic violence; when dealing with gunshot and other wounds; or when ordered in a judicial or administrative proceeding.
2) For public health activities, for example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.
3) For health oversight activities, for example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.
4) For purposes of organ donations. We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.
5) For research purpose. In certain circumstances, we may provide PHI in order to conduct medical research.
6) To avoid harm. In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.
7) For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. As we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.
8) For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.
9) Appointment reminders and health-related benefits or services. We may use Phi to provide appointment reminders or give you information about treatment alternatives or health care services or benefits we offer.

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Assistant Clinical Professor, UCLA School of Medicine

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C. Uses and Disclosures Require You to Have the Opportunity to Object.
Disclosures to family, friends and others. We may provide your PHI to a family member, friend or other persons that you indicate s involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. All other Uses and Disclosures require your written Authorization. In any other situation not described in Sections III A, B and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you chose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

IV. What Rights You Have Regarding your PHI
You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that are legally required or allowed to make.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you to an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of your regular email). We must agree to your request so long as we can easily provide it in the format you requested.

C. The Right to See and Get Copies of Your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who dies, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell in writing, our reasons for the denial and explain your right to have the denial reviewed. If you request copies of your PHI, we will charge you $15 for each page. Instead of providing the PHI you requested, we must provide you with a summary or an explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you already have consented to, such as those made for treatment, payment or health care operations, directly to you, to your family or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel or before April 14, 2003.
We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more that ne request in the same year, we will charge you $25 for each additional request.

E. The Right to Correct or Update your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) incorrect and incomplete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denials and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

V. Person to contact for information about this notice or to complain about our privacy practices.
If you have any questions about this notice or any complaints about our privacy practices or would like to know how to file a complaint with eh Secretary of the Department of Health and Human Services, please contact: Compliance Office, 100 Oceangate, Suite 100, Long Beach, CA 90802 (562)590-7495.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed above. You may also send a written complaint with person listed above. You may send a written complaint to the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. Effective Date of this Notice
This notice went to effect on April 14, 2003.

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Dear Patient,

Our clinic is updating our Cancellation Policy due to the number of patients who are wanting to get an appointment with the doctor, for paramedical procedures and facials, we will be charging 50% of the total cost of whatever treatment/s you are scheduled for. If you book a facial appointment the aestheticians will charge $350.00 for a missed facial. If you want to change your appointment time or date you are required to give us **24** hours' notice. And we will gladly re-schedule the appointment within that time frame.

Thank you for your cooperation.

I understand the above state and will comply with the policy.

Signature: ____ Date: ___________________

Printed Name: ____

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Cancellation Policy:

We require a minimum of 24 hours for any cancellation. Cancellations made within 24 hours of your appointment time will result in a 50% charge of the total cost of treatment. For facials, we charge $350 for missed appointments. Cancellations could be made by phone or email.

I understand the above stated and will comply with the policy of your office.

____________________________ ____________________________
Signature Date

____
Printed Name