The Vitiligo and Pigmentation Institute of Southern California

5670 Wilshire Blvd. Suite 650 ▪ Los Angeles, CA 90036 ▪ **Phone** (323) 467-4389 ▪ **FAX** (323)467-4488

PATIENT REGISTRATION FORM

Date: ____/____/____

PATIENT INFORMATION

Legal Name : _____
Last First Middle Initial

Date of Birth : ____/____/____ **Age:** _____ **Sex:** M F **SS# :** _____ - _____ - _____

Marital Status : ☐ **Single** ☐ **Partnered** ☐**Married** ☐ **Divorced** ☐ **Widowed**

Spouse Name : _____

Work Phone : _____ **Cell Phone :** _____

Drivers License #: _____ **State:** _____ **Exp. Date :** _____

Home Address : _____

_____
City State Zip Code

Home Phone : _____ **Cell Phone :** _____ **Email:** _____

EMPLOYMENT INFORMATION

Occupation : _____

Employer : _____

Address : _____
City **State** **Zip Code**

Work Phone : _____ **Ext.** _____

EMERGENCY CONTACT

Name: _____ **Phone Number (home) :** _____

Relationship : _____ **Phone Number (work) :** _____

INSURANCE INFORMATION: Do you have Health Insurance? ☐ **YES** ☐ **NO** (If yes, please complete below)

Primary Insurance : _____ **Secondary Insurance :** _____

Subscriber Name : _____ **Subscriber Name :** _____

Subscriber Birth Date : _____ **Subscriber Birth Date :** _____

Subscriber SS# _____ - ____ - _____ **Subscriber SS#** _____ - ____ - _____

Office Visit Co-pay : _____

**** Your co-pay is due the day of your appointment****

REFERRED BY: ☐ Current Patient ☐ Doctor ☐ Friend ☐ Internet ☐ Radio ☐ Other_____

Name of Referring Doctor: _____ Phone : _____

Address: _____City: _____ State: _____Zip _____

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MEDICAL HISTORY

PLEASE PRINT

Name : _____ _____ _____
Last First Middle Initial

Date of Birth : _____/_____/_____ **Age:** _____ **Sex:** M F **Height** _____ **Weight** _____

Chief Complaint/Reason for Today's Visit : _____

Please check all items that apply to you and/or Family Members (write family member name in space provided) Y= YOU F= FAMILY

Y	F		Y	F		Y	F	
		Eczema _____			Hearing Problems _____			Heart Murmur _____
		Psoriasis _____			Glaucoma _____			Palpitations _____
		Rash _____			Cataracts _____			Irregular Pulse _____
		Acne _____			Coronary Heart Disease_____			Varicose Veins _____
		Abnormal Moles _____			Venereal Disease _____			Phlebitis _____
		Hives _____			Herpes _____			Thyroid Disease_____
		Freq. Sun Exposure _____			High Cholesterol _____			Seizures _____
		Excessive Scarring _____			Colitis _____			Stroke _____
		Skin Cancer _____			Jaundice _____			Tuberculosis _____
		Alopecia Areata _____			Hepatitis _____			Chronic Fatigue Syndrome _____
		Recent or Progressive Hair Loss _____			Kidney Stones _____			Scleroderma _____
		Cosmetic Issues _____			Prostate Problems_____			Depression _____
		Dark Spots _____			Epstein Barr Syndrome _____			High Blood Pressure _____
		Pigmentation Loss _____			Recent Weight Loss_____			Urinary Problem _____
		Mental Illness _____			Cancer _____			Difficulty Swallowing _____
		Cardiovascular Heart Disease _____			Diabetes _____			Mental Illness _____
		Cancer (Colon, Breast or Prostate) _____			Heartburn _____			Bleeding Disease _____
		Neurological Disease (Stroke, Seizures, etc..) _____			Peptic Ulcer Disease _____			Bruise Easily _____

LIFESTYLE HISTORY

Occupation? _____ **Employer?** _____

Do you smoke tobacco? If yes, how much per day? _____ **If you quit, when did you stop?** _____

Do you drink alcohol? If so, how much per day? _____ **Do you take recreational drugs?** _____

When was your last physical exam by a Doctor? _____

MEDICAL BACKGROUND (use reverse side of this form if you need additional space)

Drug Allergies (list) _____
medications and reactions

_____

_____

Current Medications _____

_____

_____

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APPOINTMENT CANCELLATION POLICY

Dear Patients,

Please be aware of our **24 hour cancellation/no show policy**. If you fail to inform our office that you will be unable to keep your appointment within 24 hours of your **scheduled appointment time**, you will be charged a cancellation fee of **$25.00.** If you **do not arrive** for your scheduled appointment, you will be charged a **$25.00** no show fee.

In addition, for all cosmetic or procedural appointments, due to the set up and purchase of products to complete your appointment, a fee of **$100.00** will be charged if proper 24 hour notice is not received in our office.

A credit card number **must** be given to the front desk at the time of scheduling a cosmetic, aesthetic or procedural appointment, and will be kept on file and charged the cancellation fee if applicable.

Thank you,

Pearl E. Grimes M.D., FAAD

_____	_____	_____
Patient Name (print)	**Patient Signature**	**Date**

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EMAIL ALERT

If you'd like to receive special offers, office announcements or notice of upcoming studies offering payment to patients, please print your name and email address below, and we will be happy to include you on our contact list. We respect your privacy, and all information will be kept strictly confidential, and used only for the purposes listed below.

Thank you.

_____ _____

NAME DATE

_____

EMAIL ADDRESS

.....

Yes, please send me information on the following topics:

Special office promotions ☐

Office Announcements ☐

Patient Paid Research Studies ☐

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NOTICE TO OUR PATIENTS:

Each health plan varies regarding deductibles, co-pays and coinsurance. Terms are contracted between the insurance company and the patient at the time you accept the insurance. It is your responsibility to be aware of your deductibles, co-pays and coinsurance, and it will be your obligation to remit all appropriate payments as outlined in your insurance policy. These policy requirements no longer allow us to absorb any co-pays, coinsurance or deductibles.

Thank you for your cooperation.

Sincerely,

Pearl Grimes, M.D.

_____ _____

Patient Signature Date

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OFFICE POLICIES

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize The Vitiligo and Pigmentation Institute of Southern California to provide medical care and treatment, and to release my medical information to my insurance company (ies) as necessary for payment of benefits. I authorize my insurance company (ies) to pay benefits directly to The Vitiligo and Pigmentation Institute of Southern California. These authorizations remain valid and effective from the date of signing until revoked in writing.

LABORATORY / PATHOLOGY FEES & TEST RESULTS

As a part of your treatment, it may be necessary to have blood tests or a biopsy performed. **All blood and biopsy specimens are sent to outside laboratories for testing and analysis.** You will receive a **SEPARATE** bill from the lab performing the tests, and their fees are **in addition** to those charged by Dr. Grimes/VPI. Please notify the office immediately if you have questions regarding fees or services.

All results of lab work performed in our office will be mailed to you within two weeks of their completion. Notes and explanation of results by Dr. Grimes will be included. If any of the results indicate that there is a need to address them immediately, we will call you. If you have additional questions about your results, please call us.

If you do not receive your lab results in the two week period, please call us at (323)467-4389

PATIENT FINANCIAL POLICY

In order to reduce confusion and misunderstandings between our patients and the practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our Front Office Supervisor prior to treatment. We are dedicated to providing the best possible care and service to you, and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- Your insurance policy is a contract between you and your insurance company only. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you. **Therefore, our charges for your care and treatment are due at the time of service.**
- Unless either you or your health coverage carrier have made other arrangements in advance, payment is due at the time of service. For your convenience, we accept cash, check and Credit Cards. If you have a financial hardship, please make us aware of it prior to your receiving services. CARE Credit is a financing option, ask us for an application for their independent program.
- All health plans are not the same and do not cover the same services. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge for that service.
- For all services rendered to minor patients, we will hold the parent/guardian responsible for expenses incurred.
- In order to provide the best possible service and availability to all of our patients, a 24 hour cancellation notice is required. In the event of a scheduling change by our office, we will make every effort to give you the same 24 hour notice when at all possible.
- Patient balances are due within 30 days of receipt of statement. There will be a $25 charge on any outstanding balance if payment if not received in thirty(30) days unless previous arrangements have been made in advance with our Billing Office.
- Laboratory Fees - Depending on your insurance carriers policy, you may be required to pay a separate co-payment for an specimen taken during your visit.

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval or the service or authorization has been denied, you are fully responsible for all charges that your insurance company does not agree to pay. If addition you will be responsible for all deductibles, co-insurance, co-payments, and any service that your insurance company has determined not to be medically necessary.

I have read and understand the information above. I understand that my insurance company may deny coverage, and I agree to be personally and fully responsible for all charges.

_____	_____	_____
Patient or Guarantor	Print Name	Date
_____	_____	_____