South Bay
DERMATOLOGY

OFFICE USE ONLY
Patient Name: ____________________
Date: __________ Account #: ________ Reviewed by: ____

PATIENT INFORMATION

Last Name: ________________ First name: ________________ Middle Initial: ________

Address: ____
Street City State Zip Code

Home #: ________________ Cell #: ________________ Work #: ________________

Social Security: ________________ Date of Birth: ____________ Age: ________________

Sex: ________________ Marital Status: ____________ Email: ________________

Race: Caucasian Hispanic/Latino Asian African American Middle eastern
(circle one)

Languages spoken: ________________________________

Emergency:
Contact: ________________ Relationship: ____________ Phone #: ________________

Patient
Occupation: ________________ Employer: ________________________________

Referring
Physician: ________________ Primary Care
Physician: ________________________________

Pharmacy: ________________ Address: ____________ Phone #: ________________

How did you find us/referred by : ________________________________

INSURANCE INFORMATION (Please fill out if **patient is not the insured**):

Last Name
Of Insured: ________________ First Name
of Insured: ________________ MI: ____________

Address:
of insured ____
Street City State Zip Code

Home #: ________________ Cell #: ________________ Work #: ________________

Date of Birth:
of insured: ____________ Sex (of insured): ________________

Patient's relationship to the insured: ________________________________

Shirlene Jay, M.D., Inc.
3400 Lomita Boulevard, Suite 503 • Torrance, CA 90505 • (310) 257-1988

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FINANCIAL AGREEMENT – ALL PATIENTS, INCLUDING MEDICARE

Payment is required for all services rendered at that time. The patient is responsible for any/all charges not paid for by their insurance company.

I have read and understand the financial agreement. I agree to make in-full prompt payment to Shirlene Jay, M.D., Inc. when billed for any and all charges not covered or paid by valid insurance benefits for and in consideration of services rendered. Further, I authorize payment directly to Shirlene Jay, M.D., Inc. for medical insurance benefits payable to me under the terms of my policy but not to exceed the balance due for services performed for my treatments. This authorization is valid until revoked in writing.

______________________________ ______________________
Patient Signature *Date [mm/dd/yy]*

FINANCIAL AGREEMENT – MEDICARE PATIENTS ONLY

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. This authorization is valid until revoked in writing.

______________________________ ______________________
Patient Signature *Date [mm/dd/yy]*

RELEASE OF MEDICAL INFORMATION

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 application, and prescriptions.

______________________________ ______________________
Patient Signature *Date [mm/dd/yy]*

PRIVACY PRACTICES (HIPAA)

Notification and Receipt of Privacy Practices:

- By signing below, I acknowledge that I have the right and opportunity to review the Notice of Privacy Practices. Notice of Privacy Practices may be obtained by forwarding a written request South Bay Dermatology, Privacy Officer at 3400 Lomita Blvd. #104, Torrance, CA.90505.

Contact Information:

- By signing below, I authorize South Bay Dermatology to leave a message in reference to any items that assist the practice in carrying out healthcare operations. If you do not wish to be contacted at a specific location, please indicate below:

Home Phone: ☐ Do not contact me here Work Phone: ☐ Do not contact me here
Mobile Phone: ☐ Do not contact me here E-mail: ☐ Do not contact me here

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent):

Name: ______________________ Relationship: ______________
Name: ______________________ Relationship: ______________

______________________________ ______________________
Patient Signature *Date [mm/dd/yy]*

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Shirlene Jay, M.D.
Diplomate of the American Board of Dermatology
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(310) 257-1988 www.sbayderm.com

APPOINTMENT CANCELLATION POLICY

In order to maintain efficiency in the scheduling of our patients, our office has found it necessary to implement an appointment cancellation policy.

If you wish to cancel or reschedule your appointment, please call at least 24 hours in advance of your scheduled time.

A $50.00 cancellation fee will be charged immediately to your account if our office is not given a timely notice. This is not covered by your insurance.

A $100.00 cancellation fee will be charged to your account for surgical and or cosmetic procedures if our office is not given a timely notice.

I have been informed and acknowledge this policy.

Signature:____

Print Name:____

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 of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in 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 relate 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 both 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 of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated 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 Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators 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 one 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 of 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 signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services ____________________

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or 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. By my signature below, I acknowledge that I have received a copy.

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: ____________________ ____________
Physician's or Authorized Representative's Signature (Date)

Shirlene Jay, M.D., Inc.
Print or Stamp Name of Physician, Medical Group, or Association Name

By: ____________________ ____________
Patient's or Patient Representative's Signature (Date)

By: ____________________
Print Patient's Name

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

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(9-13)

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PATIENT HEALTH QUESTIONNAIRE

PAST MEDICAL HISTORY: Please circle if you had or have any of the following conditions:

anxiety	coronary artery disease	hyperthyroidism
arthritis	depression	hypothyroidism
artificial joints date ________	diabetes type ____	leukemia
asthma	end stage renal disease	lung cancer
atrial fibrillation/irregular heartbeat	GERD	lymphoma
bone marrow transplant	hearing loss	prostate cancer
BPH	hepatitis	radiation treatment
breast cancer	hypertension	seizures
colon cancer	HIV/AIDS	stroke
COPD	hypercholesterolemia	other: ____________

PAST SURGERIES
If yes, what and when? ____________________

SKIN DISEASE HISTORY: Please circle if you had or have any of the following conditions:

acne	dry skin / itchy	poison ivy
actinic keratosis	eczema	precancerous moles
asthma	flaking or itchy scalp	psoriasis
basal cell skin cancer date/area: ____________	hay fever/allergies	squamous cell skin cancer date/area: ____________
blistering sunburns	melanoma date/area: ____________	family history of melanoma whom? ____________
Do you use a tanning salon? Y/N	Do you use sunscreen? Y/N	If yes, what SPF? ________

CURRENT MEDICATIONS: ____________________

____
(including over-the-counter, vitamins or supplements)

ALLERGIES TO MEDICATION: ____________________

Please describe the type of allergic reaction you have : ____________________

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SOCIAL HISTORY: Please circle and fill in your answer if appropriate

Smoker present or past If currently smoker list amount:	recreational drug use If yes, list type:	alcohol use If yes, list amount/week:

REVIEW OF SYSTEMS: Please circle if you have any of the following conditions:

fevers or chills	dizziness	Tuberculosis
night sweats	abdominal pain	emphysema
unintentional weight loss	ulcers	shortness of breath
muscle aches	cough	phlebitis/painful veins
joint aches	sore throat	herpes oral/genital

ALERTS: Please circle if you have any of the following conditions:

pacemaker	difficulty stopping bleeding	pregnancy/planning pregnancy
defibrillator	blood thinners	breastfeeding
artificial joints (within past 2 years)	allergy to adhesives	HIV/AIDS
artificial heart valve	allergy to antibiotic ointments	hepatitis B or C
stent	allergy to lidocaine	history of MRSA
premedication prior to procedures	rapid heartbeat w/epinephrine	immunosuppression
light headedness during procedures	yeast infection w/antibiotics	problems with scarring

PATIENT SIGNATURE

Signature: ______________________________ Date: ______________________________

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