ALAN A. SEMION, M.D., INC.
DERMATOLOGY AND DERMATOLOGIC SURGERY
SUNRISE OFFICE PARK
729 SUNRISE AVENUE, SUITE 700
ROSEVILLE, CALIFORNIA 95661
PHONE: 916-782-7546 FAX: 916-782-1596

PATIENT INFORMATION (PLEASE PRINT)

TODAY'S DATE_____/_____/_____

NAME_____
LAST FIRST MIDDLE

MAILING ADDRESS_____
STREET CITY STATE ZIP

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

DOB_____/_____/_____ AGE_____ SEX_____ MARITAL STATUS_____ **SSN**_____

PARENT OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

RELATIONSHIP TO PATIENT_____

NAME_____
LAST FIRST MIDDLE

MAILING ADDRESS_____
STREET CITY STATE ZIP

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

DOB_____/_____/_____ AGE_____ SEX_____ MARITAL STATUS_____ **SSN**_____

INSURANCE INFORMATION (PLEASE PRESENT ONLY PRIMARY AND SECONDARY INSURANCE CARDS AT TIME OF SERVICE – NO MEDI-CAL, NO HMO NO COVERED CALIFORNIA, NO PATHWAY PPO, NO WORK COMP, NO THRID PARTY)

PRIMARY INS INFO_____ **SECONDARY INS INFO**_____

CLAIMS ADDRESS_____ **CLAIMS ADDRESS**_____

NAME OF POLICY HOLDER_____ **NAME OF POLICY HOLDER**_____

DOB_____/_____/_____ **RELATION TO PATIENT**_____ **DOB**_____/_____/_____ **RELATION TO PATIENT**_____

ID #_____ **SSN**_____ **ID #**_____ **SSN**_____

EMPLOYER NAME_____ **PHONE**_____ **EMPLOYER NAME**_____ **PHONE**_____

OTHER FAMILY MEMBERS THAT ARE PATIENT'S-_____ **REFERRED BY**_____

EMERGENCY CONTACT_____ **PHONE**_____

FAMILY DOCTOR_____ **PHONE**_____ **PHARMACY**_____ **PHONE**_____

I authorize the release of medical information to my family physician, referring physician and/or consulting physicians if needed and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to ALAN A. SEMION, M.D., INC.

PATIENT, PARENT OR RESPONSIBLE PARTY (SIGNATURE)_____ **DATE**_____/_____/_____

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the patient's financial responsibility to pay for co-payments and non-insurance services at the time of visit. Health insurance policies are a contract between you and your insurance company. REGARDLESS of insurance status our office is submitting claims as a courtesy and if we are unable to obtain proper payment from your insurance company within 90 days we will require payment in full by the patient/responsible party at that time and/or require your assistance in doing so. An itemized statement can be provided to those who wish to submit claims on their own.

UNACCOMPANIED MINORS must have a signed consent by parent or guardian in order to treat and cash or check or a credit card on file to cover co-pays, otherwise, all non-emergency visits will be cancelled and rescheduled.

MISSED APPOINTMENTS or appointments cancelled less than 24 hours prior to appointment will access a fee of $ 50.00

Thank you for understanding our policies, however, if you have any questions or unique circumstance, please do not hesitate to meet with our office manager or billing agent.

PATIENT, PARENT OR RESPONSIBLE PARTY (SIGNATURE)_____ **DATE**_____/_____/_____

EMAIL_____

WE GLADLEY ACCEPT: CASH OR CHECK ($20.00 FEE ON ALL RETURNED CHECKS WILL BE ASSESSED) VISA, MASTERCARD, DISCOVER AND DEBIT.

PATIENT CONSENT FORM

For the office of Alan A. Semion, M.D., Inc.

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy, The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain the patients' consent for uses and disclosures of health information about the patient to carry out treatment payment, or health care operations.

As out patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and infomation about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part your **PHI**. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ______________________________ Signature ______________________ Date __________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan. We have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our, policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

ALAN A. SEMION, M.D., INC.
DERMATOLOGY and DERMATOLOGY SURGERY
COSMETIC DERMATOLGY
729 SUNRISE AVENUE, SUITE 700
ROSEVILLE, CALIFORNIA 95661

TELEPHONE (916) 782-7546
FAX (916) 782-1596

Dear Patient:

Due to policy provisions in your contract with your insurance carrier we are obligated to collect all patient responsibility balances.

If your insurance policy has provisions such as deductibles, co-insurances, or co-payments please note that these are provision that you have agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

If a portion of your fees are applied to an annual out of pocket maximum, and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for those Medicare patients that may have any medical services that are eligible under Medicare, we are legally obligated to collect the patient responsibility co-insurance, co-payments or deductible under the terms of the ANTI-KICKBACK LAWS.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we must be bound by all provisions of insurance policy and federal law. If you have any issues or concerns with your insurance we will be more than happy to assist in the resolution of those issues or concerns. Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Sincerely,

Alan A. Semion, M.D.

Patient:_____ Date: _____

ALAN A. SEMION, M.D., INC.
DERMATOLOGY and DERMATOLOGY SURGERY
COSMETIC DERMATOLGY
729 SUNRISE AVENUE, SUITE 700
ROSEVILLE, CA 95661

TELEPHONE: (916) 782-7546
Fax (916) 782-1596

Dear Patient,

MEDI-CAL

_____ Alan A. Semion, M.D. is not currently contracted with any **Medi-Cal** lines of business/insurance. It is against the law for Dr. Semion to see **Medi-Cal** patients in exchange for direct payment. It is also against the law doe **Medi-Cal** patients not to inform the provider of their **Medi-Cal** status.

Therefore, by signing below you are stipulating that you do not have **Medi-Cal** insurance nor are you currently applying for **Medi-Cal** insurance or any **Medi-C**al line of business and will contact Dr. Semion's office should you obtain **Medi-Cal** insurance. If you do obtain **Medi-Cal** insurance during the course of your care you will be discontinued from further / future visits with Dr. Semion and we will forward your records to your new Dermatologist.

Signature Date

COVERED CALIFORNIA

_____ Alan A. Semion, M.D. is not currently contracted with any Covered California Plan lines of business to include **BLUE CROSS PATHWAY, BLUE SHIELD, MEDI-CAL** and/or **HMO's.** By signing below you agree not to file any grievance against Alan A. Semion, M.D. for services rendered. I understand it is The patient's responsibility to verify coverage and plan participation.

Signature **Date**

Medical History (For Dermatology Appointment)

Alan A. Semion, MD

Patient Name: _____ Date of Birth: ____/____/____ Today's Date: _____

Phone: Home: (____) _____ Work: (____) _____ Cell: (____) _____ Age: _____

E-mail Address: _____

Reason for today's visit (circle one): RASH MOLES BUMPS SKIN CANCER PSORIASIS OTHER:

Are you allergic to any medications? ☐ Yes ☐ No

If yes, list: 1. _____ 2. _____

List all medications (pills) you are currently taking:

1: _____

2. _____

3. _____

4. _____

5. _____

List all topical medications (creams, etc) you are using:

1. _____

2. _____

3. _____

4. _____

5. _____

SKIN HISTORY:

Have you ever visited a dermatologist? ☐Yes ☐No When? _____

Reason? _____ Treatment: _____

Would you describe your CURRENT (within the last 2 years) sun exposure history as: ☐Minimal ☐Moderate ☐Maximal

Do you actively seek a tan ('laying out' or tanning bed)? ☐Yes ☐No Do you regularly use sunscreen? ☐Yes ☐No

Have you ever had skin cancer? ☐Yes ☐No If yes, what kind? _____

Do you form keloids (thick scars)? ☐Yes ☐No

Do you have a history of any specific skin diseases? ☐Yes ☐No

If yes, explain: _____

GENERAL MEDICAL: Do you have now, or have you ever had:

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Seizures	☐	☐	Arthritis	☐	☐
Seasonal Allergy	☐	☐	Depression	☐	☐	Ulcers/Reflux	☐	☐
High Blood Pressure	☐	☐	Thyroid Disease	☐	☐	Lip/Fever Blisters	☐	☐
Heart Valve Dis.	☐	☐	Diabetes	☐	☐	HIV Infection	☐	☐
Phlebitis	☐	☐	Glaucoma	☐	☐	Cancer	☐	☐
Blood Clots	☐	☐	Cataracts	☐	☐	Hepatitis	☐	☐

SOCIAL HISTORY:

	Yes	No		Yes	No
Do you smoke cigarettes?	☐	☐	Do you drink alcohol?	☐	☐
Have you ever had local or dental anesthesia?	☐	☐	Do you need to take antibiotics	☐	☐
Any bad reaction?.....	☐	☐	before dental appointments?		
Are you pregnant or breastfeeding?	☐	☐			

What is your occupation? _____

FAMILY HISTORY:

Do you have any history of skin cancer, melanoma, or skin disease? ☐Yes ☐No If yes, what type and when? _____

List surgical procedures you have had in the last 6 months: _____

List any other conditions you've seen a doctor for (not mentioned above): _____

Completed by: _____ _____

Patient/Parent (Signature) (Date)