Welcome! Thank you for choosing Halcyon Dermatology

Your health care needs are our most important priority. Our goal is to be available and responsive to your needs, and to provide Best in Class medical care for every patient. The following information is provided to introduce you to our practice and help you plan your office visits. Please let us know if you have any questions or would like additional information.

- Office hours are 9am-4:30pm Monday through, Thursday and 9am-1pm on Fridays.
- Please call (949) 266-0216 during regular office hours to schedule an appointment.
- Our office does not provide childcare supervision during appointments. No children under age 12 may be left unaccompanied in the waiting room.
- You will receive a text and/or email prior to your visit to confirm your appointment.
- If you are unable to keep an appointment, please call the office in advance. After hours, you may leave a voicemail.
- **Our specialty practice has a "No Show" fee of $50** which is charged if you do not cancel 24 hours in advance as permitted by your insurance. We understand things may come up unexpectedly; an exception will be made in case of an emergency. More than 3 no shows or late cancellations may result in dismissal from our practice.
- If you are running late for an appointment, please call our office as we may be able to accommodate your arrival with our schedule. If you are more than 10 minutes late, your appointment may need to be rescheduled as a courtesy to our other patients.
- If you need to contact the physician after hours, an on-call physician will be notified and respond to your call. Please call 911 in case of any emergency.
- Please bring a photo ID and your medical insurance card on your first visit as part of our privacy/identify theft program.
- Halcyon Dermatology maintains compliance with federal and state HIPAA privacy laws. If you would like health information released to yourself or to another person, you must sign a HIPAA release identifying the individual to whom you want information released.
- Co-pays and deductibles are due at the time of your appointment. Bills are payable within 30 days of receipt. We bill insurance on your behalf. However, the balance due is your responsibility.
- Our practice uses an electronic medical record system, and you may register for the Patient Portal to access your medical record information, lab tests, and physician visit notes.
- Once you are a registered patient, you may communicate electronically with Halcyon Dermatology using the Patient Portal or Klara secure text messaging. Please call the office if you have a problem, need help, or have an urgent matter.
- Our office does not permit photography, video, or audio recording in the office.
- We offer telemedicine visits for your convenience when applicable.
- Our practice will need to re-establish care as a new patient if you are not seen for two consecutive years.
- Our practice maintains high standards of excellence and integrity from our staff; we strive to treat each patient with courtesy, respect, and mutual trust. We maintain a zero tolerance for inappropriate behavior on the phone and in the office.
- Please refrain from speaking on your mobile phone while in the exam and waiting rooms. You may forfeit your appointment if you are on the phone when we are ready to start your visit.

We look forward to providing you with the quality medical services to support your health care needs. Wishing you the best of health.

I have reviewed the information above, understand, and was offered the opportunity to ask questions.

X______________________ ______________________ ______________

Patient Signature | Patient Name | Date

P 949.266.0216 F 888.454.2998
24431 CALLE DE LA LOUISA STE 200, LAGUNA HILLS, CA 92653
WWW.HALCYONDERM.COM

Patient Name:____ Signer's Birth Date:___________________________________
Signer's Address:____Signer's Phone: ___________________

<u>All Patients - Medication Authority</u>

I understand and give my consent for Halcyon Dermatology to retrieve/review my medication history. I understand this will become part of my medical record. A medication history is a list of medicines that all my healthcare providers have recently prescribed. It is collected from a variety of sources including: a patient's pharmacy, health plans, and other healthcare providers. Without an accurate medication history, providers at Halcyon Dermatology will not be able to safely prescribe any medications for you or perform any procedures.

X Signed:____ Date:________________

Print Name:____ Relationship (if not signed by patient): _____________

<u>All Patients - Privacy and Open Payments Notice</u> (Please view Privacy and Open Payments Notices here: https://www.halcyonderm.com/portal/)

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices and Open payment notice, and a copy of any amended Notice of Privacy Practices will be available at each appointment.

X Signed:____ Date:________________

Print Name:____ Relationship (if not signed by patient): _____________

<u>All Patients - Financial Policy</u>

I have read and understand the financial policy statement. I agree to make in-full prompt payment 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 Halcyon Dermatology under the terms of my policy. This authorization is valid until revoked in writing. The SIGNER must complete THEIR OWN information here (if different from the patient):

X Signed:____ Date:________________

Print Name:____ Relationship (if not signed by patient): _____________

<u>Medicare Patients Only – Financial Policy</u>

I authorize any holder of medical or other information about me to release 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.

X Signed:____ Date:_________________

Print Name:____________________________________ Relationship (if not signed by patient): _________________

Please list all persons (family/friends) to whom your protected health information may be disclosed other than yourself. I authorize release of information to the named persons:

Name:____ Relationship/Phone____

Name:____ Relationship/Phone____

X Signed:____ Date:________________

Print Name:____ Relationship (if not signed by patient): _____________

Please list an **email address** where we are authorized to contact you ____

Would you like to receive emails regarding **cosmetic practice specials such as treatments and products?** □yes □no

X Signed:____ Date:________________

PATIENT INFORMATION

Date: ________________

Name: ____
Last First M.I.

Address: ____
Street City State Zip

Please list your preferred phone numbers where we are authorized to contact you and leave a message:

Phone: 1. (_____)______________________ 2. (_____)____________________ 3. (______)________________

Circle one: **HOME/CELL** **CELL/WORK** **CELL/WORK**

Date of Birth:_____________ **Sex:** ☐M ☐F **Social Security Number:**_______________

Emergency Contact Name:_____________________Phone:_________________ Relationship:____________

Do you have a **POA** (Power of Attorney)? ☐**YES** ☐**NO** Name:__________________ Relationship:_____________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated

Patient Race: ☐White ☐Hispanic ☐Asian ☐Black/African American ☐Other:______________

Ethnicity: ☐Hispanic ☐Non-Hispanic **Preferred Language**: ☐English ☐Spanish ☐Other:_____________

Employment Status: ☐Full Time ☐Part-Time ☐Self-Employed ☐Retired
Employer Name: ____

Employer Address: ____
Street City State Zip

Primary Care Physician:________________________________**Telephone**:_________________________

How did you find us? ☐Yellow Pages ☐Insurance ☐Internet ☐Other ________________
☐Physician (Name:__________________) ☐Family/Friend (Name:_________________)

Insurance Information

Please check one: ☐Self Pay (no insurance) ☐Patient IS the Policy Holder ☐Patient IS NOT the policy holder

If the above named patient is not the primary policy holder, please fill out the following:
SUBSCRIBER/PRIMARY POLICY HOLDER INFORMATION:
Name:____
Last First M.I.

Date of Birth:________________Social Security Number:_________________ Sex: ☐M ☐F

ID Number:____________________Group Number:________________________________

Address:____
Street City State Zip

Telephone:
(___)____________________(___)__________________(____)_______________________
Home Mobile Work ext

P 949.266.0216 F 888.454.2998
24431 CALLE DE LA LOUISA STE 200, LAGUNA HILLS, CA 92653
WWW.HALCYONDERM.COM

Name:____Date:_______________________________
Date of Birth:______________ Sex: □M □F Referring Physician:____________________________________
Reason for Visit:_ _______________________________________
Pharmacy Name & Address/Cross streets:__________________________Pharmacy Phone:____________

Medical History Form

Medications and Over the Counter meds/supplements:

Dose Frequency

____
____
____

Do you have an Advanced Care plan? □Yes □No
If Yes, name of POA or decision maker: _________________________________

Allergies: Please list any medication allergies that you have.

____
____
____

Alerts:
If female, are you pregnant, nursing, or think you may be pregnant? □Y □N
If female, are you planning a future pregnancy? □Y □N

Are you allergic to:

Latex	□ Yes	□ No
Lidocaine	□ Yes	□ No
Adhesive Tape	□ Yes	□ No
Bee Stings	□ Yes	□ No

Do you have a history of cold sores? □Yes □No
Do you have a history of fainting or feeling faint with needles? □Yes □No
Do you have a pacemaker? □Yes □No
Are you on a blood thinner medication? □Yes □No

Social history
Do you drink alcohol? □Yes □No
If Yes, how many times in the past year have you had more than 4 drinks in a day? _________
Do you use any recreational drugs: □Yes □No
Do you smoke? □No □Yes
Packs per day__________
Smoking start date:____________
end date:__________________
[Staff note: Enter into MIPS]

Occupation: ________________

Have you received the following vaccines?:
Covid Vaccine □No □Yes______(Date)

Please indicate if you have had any of these conditions.

	Notes
□Basal Cell Carcinoma	
□Squamous Cell Carcinoma	
□Malignant Melanoma	
□Actinic Keratoses	
□Abnormal Moles	
□Other suspicious lesions	
□Other skin condition	

Past Medical History

Asthma/COPD/Emphysema	□Yes □No
Bleeding disorder/blood clot	□Yes □No
Depression	□Yes □No
Diabetes	□Yes □No
Crohn's/ulcerative colitis	□Yes □No
Heart Disease	□Yes □No
Hepatitis	□Yes □No
High blood pressure/ cholesterol	□Yes □No
HIV/AIDS	□Yes □No
Joint replacement/ artificial heart valve	□Yes □No
Stroke	□Yes □No
Seizures/Epilepsy	□Yes □No
Thyroid Disease	□Yes □No
Tuberculosis	□Yes □No
Other	

____
____

Patient Surgical History: Please list any surgeries and/or hospitalizations including dates:□none

____
____
____

Patient Family History: please list any family history of skin disease, cancers, or other diseases:

____
____

Review of Systems
Do you have any of these symptoms?

General	
Weight change	□Yes □No
Fatigue/energy loss	□Yes □No
Fevers	□Yes □No
Heat/cold intolerance	□Yes □No
Night sweats	□Yes □No
Immune	
Frequent infections	□Yes □No
Swollen glands	□Yes □No
Eyes	
Light sensitivity	□Yes □No
Blindness/loss of vision	□Yes □No
Skin	
Rash	□Yes □No
Itching	□Yes □No
Change in hair or nails	□Yes □No
Ear/Nose/Throat	
Sinus Problems	□Yes □No
Trouble swallowing	□Yes □No
Changes in voice	□Yes □No
Digestive	
Abdominal pain	□Yes □No
Heartburn or ulcers	□Yes □No
Loss of appetite	□Yes □No
Nausea or vomiting	□Yes □No
Constipation or Diarrhea	□Yes □No
Heart	
Murmur	□Yes □No
Chest pain	□Yes □No
Irregular heart beat	□Yes □No
Swelling in feet	□Yes □No
Respiratory	
Wheezing	□Yes □No
Shortness of breath	□Yes □No
Bladder	
Frequent urination	□Yes □No
Painful urination	□Yes □No
Bladder leakage	□Yes □No
Reproductive	
Menstrual problems	□Yes □No
Miscarriages	□Yes □No
Hematologic	
Anemia	□Yes □No
Bleed or bruise easily	□Yes □No
Blood clots	□Yes □No
Neurologic	
Headaches/migraines	□Yes □No
Dizziness /Fainting	□Yes □No
Numbness/tingling	□Yes □No
Psychiatric	
Mood changes	□Yes □No
Depression	□Yes □No
Anxiety/nervousness	□Yes □No

Reviewed by MD:________________Date:________