CALIFORNIA SKIN & LASER CENTER

1617 Saint Marks Plaze, Ste. C
Stockton, California 95207
(209) 956 - 4260
(209) 475 - 6002 Fax

999 S.Fairmont Ave., Ste. 120
Lodi, California 95242
(209) 333 - 1382
(209) 334 - 1047 Fax

2382 Maritime Dr #100, Elk Grove, CA 95758
(209) 956 - 4260

www.californiaskinlaser.com

Today's Date : ___/___/_____

Patient Name : _____ _____ _____
Last Name Middle Name First Name

Address : _____ _____ Please Select _____
Street City State Zip

Home Phone : (___) - ___ - ____ Work Phone : (___) - ___- ____ Ext: ____ SSN : ____-___-_____

Date of Birth : MM / DD / YYYY Age : _____ Driver's License# : _____

Email Address : _____ All right to contact by E-mail? ☐ Yes ☐ No

Occuptation : _____ Place of Employment : _____

Marital Status : ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced Sex : ☐ Male ☐ Female

Spouse Name : _____ Telephone : (___) - ___ - ____

Address : _____ _____ Please Select _____
Street City State Zip

Place of Employment : _____ Telephone : (___) - ___ - ____

Address : _____ _____ Please Select _____
Street City State Zip

SSN : ____-___-_____ Date of Birth : MM / DD / YYYY

Subscriber / Responsible Party (If different from patient)

Responsible Party : _____ Date of Birth : MM/ DD / YYYY

SSN : ____-___-_____ Driver's License# : _____

Responsible Party Address : _____ _____ Please Select _____
Street City State Zip

Occupation : _____ Company Name : _____ Telephone : (___) - ___ - ____

Address : _____ _____ Please Select _____
Street City State Zip

Referred By : _____ Primary Care Physician : _____

How did you learn about our office? _____

**INSURANCE INFORMATION (Please present insurance card at time of check in.)

☐ 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 applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature : _____ Date : ___/___/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filled, coverage will be preverified be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

***** A $40 FEE WILL BE CHARGED TO PATIENT FOR ALL MISSED APPOINTMENTS *****

Patient Signature : _____ Date : ___/___/_____

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Patient Name : _____ Date of Birth : MM / DD / YYYY Date : ___/___/___

Primary reason for today's visit : _____

Are you under physician(s) care? ☐ Yes ☐ No Which MD(s)? _____

Explain : _____

Who is your primary care physician? _____

Are you allergic to anything? ☐ Yes ☐ No What? _____

Women Only Are you pregnant and/or planning pregnancy? ☐ Yes ☐ No Are Your menses? ☐ Reg ☐ Irreg ☐ None

List any medications that you are currently taking (include over-the-counter, vitamins, herbals, etc.) :

_____

_____

Do you have now or have you ever had diseases or conditions of : (Please check Yes or No)

Arthritis/Joint Problems	☐ Yes	☐ No	Artifical Joint	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Bladder Problems	☐ Yes	☐ No	Blood Clots	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Cataracts/Glaucoma	☐ Yes	☐ No	Convuisions/Epilepsy	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Emotional Problems	☐ Yes	☐ No	GI/Stomach Problems	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Heart Disease/Attack	☐ Yes	☐ No	Have you had or been	☐ Yes	☐ No	Explosed to HIV/AIDS?	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Hepatits	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Liver/Gall Bladder Disease	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Phlebitis/Vein inflammation/Circulation	☐ Yes	☐ No
Polycystic Ovaries	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	VD/Sexuality Transmitted Problems	☐ Yes	☐ No
TB/Lung Problems	☐ Yes	☐ No						

Other medical problems :

_____

List any surgical procedures in the last 6 months :

_____

SKIN			**Explain**
Have you had skin cancer?	☐ Yes	☐ No	_____
Has anyone in your family had skin cancer?	☐ Yes	☐ No	_____
Do you have a history of any specific skin disease?	☐ Yes	☐ No	_____
Do you develop keloids (scars) after surgery?	☐ Yes	☐ No	_____
Do you bleed easily?	☐ Yes	☐ No	_____
Are you prone to herpes (fever blister) outbreaks?	☐ Yes	☐ No	_____
Do you develp skin rashes in reaction to any medications, food, or the environment?	☐ Yes	☐ No	_____

SOCIAL			**Explain**
Do you drink alcohol?	☐ Yes	☐ No	_____
Do you use recreational drugs?	☐ Yes	☐ No	_____
Do you smoke/chew tobacco?	☐ Yes	☐ No	_____

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ASSIGNMENT OF INSURANCE BENEFITS

☐ I hereby authorize direct payment of surgical/medical benefits to Gerald N. Bock, M.D. for professional services rendered by him or under his supervision. I understand that I am financially responsible and agree to pay, in a current manner, for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

☐ I hereby authorize release of any medical or incidental information directly to/from Gerald N. Bock, M.D. that may be necessary for either medical care or in the processing of claims/ applications for financial benefits.

MEDICARE OR MEDI-CAL

☐ I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

REGARDING YOUR INSURANCE

We will directly bill insurance companies for which we are contracting providers. Patients with coverage from Health Maintenance Organizations (HMO's), Preferred Provider Organization (PPO's), Individual Practice Association's (IPA's) or Managed Care Plans that **require** a referral from a Primary Care Physician must provide us with a **written referral** on the day of the appointment or will be rescheduled. In the event that you do not have a referral and wish to be seen, you must be prepared to pay for your visit that day. Payment is expected at the time of service unless prior arrangements have been made.

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE AS VALID AS THE ORIGINAL.

Patient's Name : _____

Patient Signature : _____ Date : ___/___/_____

Parent/Guardian Name : _____
(if under 18 years Old)

Parent/Guardian Signature : _____ Date : ___/___/_____
(Must sign if patient under 18 years Old)

To Our Patients, Service People, and Visitors

We have arrived at a moment when the covid vaccine is available to all California adults. Those who are vaccinated have performed a service not only to themselves but to their relatives, friends, and neighbors, in fact to the entire community. The more people vaccinated, the safer we will all be, and the more quickly the economy will recover. Our entire staff has been vaccinated for some time, but although the vaccines are very protective, they are not 100% perfect. For the protection of our staff and patients, as of June 1, 2021, we will require all adults wishing to enter our office to present proof of vaccination or a written medical excuse explaining why they cannot be vaccinated. I understand there will be people who will disagree with this, as there are people who disagree with the requirement that their children be vaccinated before starting school.

Unfortunately, we cannot please everyone, and our job is to do the best that we can in dealing with the facts we are facing.

Gerald N. Bock MD

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Patient Name : _____ Date : ___/___/_____

Account Number : _____

If family, friends or others inquire by phone or in person if you/patient are here or have been here at the office to see doctor, do we have your permission to let them know?
Specific Person(s) & Relationship to you :

_____
_____
_____
_____

While you/patient are being seen by the nurse and/or doctor today, who among family and friends that are with you, is it alright to share health information with?

Family : ☐ Yes ☐ No

Friends : ☐ Yes ☐ No

Billing or clinical information may be sent to your home address or it may be necessary to contact you by phone.

Do we have a permission to contact you at your home telephone number? ☐ Yes ☐ No If (No) Alertnate Phone#: (___) - ___ - ____

Do we have permission to send correspondence to your home address ☐ Yes ☐ No

(If No) Alternate Address : _____ (Street) _____ (City) Please Select (State) _____ (Zip)

PROCEDURE "NO SHOW" OR CANCELLATION CHARGE NOTIFICATION

Our office has implemented a "NO SHOW" office charge policy. If you fail to keep your appointment for a procedure, or you give us less than a 24 hour notice that you are canceling your appointment, you will be charged the equivalent of the scheduled procedure up to $200.

☐ I have read and understand the policy noted above.

Patient's Name : _____

Signature of Patient or Guardian : _____ Date : ___/___/_____

To all our patients:

In order to serve you better, we have hired a third party firm to contact you to remind you of your scheduled appointments and to send you a survey to rate our performance. This means we will give them your email address and cell phone number, which will be kept confidential.

Please confirm with the front desk if you do not wish to participate.

Thank You.

I wish to receive email and/or text message reminders. ☐ Yes ☐ No

Email : _____ Cell Phone : (___) - ___ - ____

Signature : _____ Date : ___/___/_____

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To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient. Currently we all are expected to pay at the time a service is rendered or an object is purchased. In medicine the situation has been somewhat different because many services are covered by insurance, and the size of the payment due from the patient was not known, until after the insurance had paid. Then, a bill was sent to the patient for the balance due. However, we currently find ourselves in a situation where our payments are declining and insurance payments are increasingly tardy, while our expenses continue to increase. Our staff and our suppliers expect to be paid in a timely fashion, even if the insurance company finds it to their benefit to delay payment as long as they can. Currently if frequently takes 3 to 6 months before we are reimbursed for services rendered. While we have made slight progress with the insurance companies, we are taking steps to reduce further delays in payments.

Because of these changes, we have implemented a similar policy similar to that used by hotels and most other businesses. We will no longer be billing to co-payments. You will be asked for a credit card number at the time you check in and the information will be held securely until all your insurances have paid their portion, and notified us of the amount of your co-payment. At the time, any remaining balance owed by you will be charged to your card is the identical amount which we would have billed you in the past. Our average co-payments billed has been $10 - $40.

This arrangement will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

We will keep your credit care information very secure. Unless it is being used that day, it will be kept locked up with only two senior staff members having keys. If you desire, and if you have no pending future appointments, we will destroy your information after the charge has been paid. If that is the case, we will need to obtain the information again at the time you next schedule an appointment.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, do not hesitate to ask. Thank you for your understanding in this matter.

Gerald N. Bock MD/California Skin & Laser Center

☐ I authorize Dr. Gerald N. Bock/California Skin Laser Center to charge outstanding balances on my account to the following credit card.

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

Account # : _____ Exp. Date : MM / DD / YYYY

Name on card (please print) : _____

CVV_____

Billing address _____ City _____ State_____ Zip code_____

Signature : _____ Date : ___/___/_____

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CONDITIONS OF REGISTRATION

CONSENT FOR TREATMENT: The undersigned consents to the performance of all routine medical care and treatment (e.g., laboratory procedures, x-ray examinations, anesthesia, therapies, etc.), which may be performed on an outpatient basis under the instruction of the treating physician for each patient.

FINANCIAL OBLIGATION, BENEFITS ASSIGNMENT: I understand I am responsible for all charges incurred. I authorized all insurance benefits to be paid directly to Dr. Gerald N. Bock, M.D. for service (s) rendered. If my insurance does not cover all charges, I agree to pay any difference upon request. If my insurance fails to pay within a reasonable time, I understand that I will be required to pay the bill in full. Should the account be referred to any attorney or collection agency for collection, I shall pay actual attorney's fees and collection expenses.

RELEASE OF INFORMATION: The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, the office may disclose portions of the patient's record, including his/her medical records, to any person or corporation which is or may be liable, for all or any portion of the official charge, including but not limited to insurance companies, health care service plans, or workers' compensation carriers. To ensure coordination of my medical care with primary care physician and/or referral source, I authorize the release of my medical information.

AUTHORIZATION: The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

OTHER BILLS: Office statements contain charges only for services provided by Dr. Bock. Patients may also receive separate bills from pathology services, radiologists, physicians, and ambulance services.

NOTIFICATION: The undersigned certifies that he/she has been actively encouraged on how to report concerns related to care, treatment, services, and patient's safety issues by calling the California Dept. of Public Health Services (916) 558-1784, or the Joint Commission hotline (800) 944-6610.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient Signature | **Date** | **Witness**

Guardian/Representative | **Date** | **Relationship**

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COSMETIC INTEREST QUESTIONNAIRE

Patient Name _____

Date _____

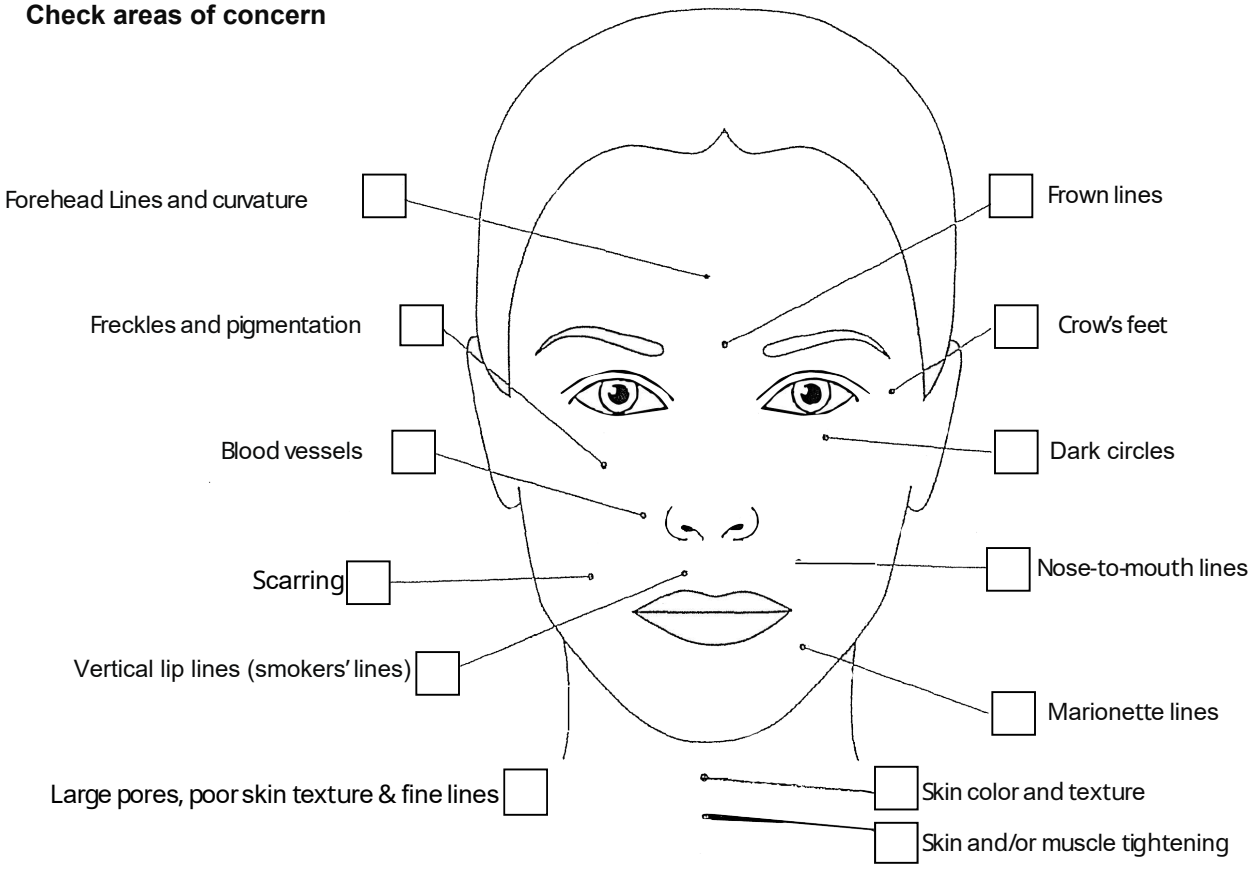
What is your reason for the visit today? _____

What concerns apply to you? Please check all that apply

- ☐ Skin care advice
- ☐ Skin care products
- ☐ Wrinkles
- ☐ Stretch marks
- ☐ Scarring Skin care
- ☐ Hair removal
- ☐ Facial veins
- ☐ Facial redness
- ☐ Brown spots
- ☐ Uneven skin tone
- ☐ Facial drooping
- ☐ Skin laxity
- ☐ Acne
- ☐ Enlarged pores
- ☐ Blackheads/whiteheads
- ☐ Longer/Fuller Eyelashes
- ☐ Neck
- ☐ Spider veins

What is your skin type ○ Dry ○ Combination ○ Oily ○ Normal

Check areas of concern



- ☐ Improvement of body fat, skin wrinkles and tightening
- ☐ Arm fat reduction and skin tightening

☐ Approval to contact you

Best phone number to reach you: _____

☐ Approval to send you information on Products and Services (Including special offers)

Email Address _____

APPOINTMENT TIME FOR COSMETIC CONSULTATION LIMITED TO HALF HOUR/ UP TO 2-3 SUBJECTS CAN BE DISCUSSED