Samireh Z. Said, M.D., Inc.
American Board of Dermatology, Diplomate
American Society of Dermatologic Surgery, Fellow
American College of Mohs Surgery, Fellowship Trained

Date of Visit: ___ / ___ / _____

New Patient Paperwork

Name (Last, First, MI): _____ ❑ Jr ❑ Sr

Sex: ❑ M ❑ F DOB: ____ / ____ /____ Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed

Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Employer name: _____

Work Address: _____

Type of insurance: _____ Name: _____ Policy #: _____

Patient Basics: *Race*: ❑ White ❑ Native American ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Other

Ethnicity: ❑ Hispanic/ Latino ❑ Not Hispanic/Latino ❑ Unknown

Primary Care Physician: _____ Telephone: _____

PCP Address/City: _____

Who referred you to our office? ❑ Dr. _____ ❑ Other: _____

❑ Family/friend: _____

Preferred Pharmacy: _____ City: _____

Cross Streets: _____ and _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Allergies: _____

_____

Medications: _____

_____

_____

Pertinent History: ❑ Basal cell carcinoma ❑ Dysplastic nevi ❑ Squamous Cell Carcinoma ❑ Family History of Melanoma ❑ Melanoma ❑ Family history of non-melanoma skin cancer (SCC or BCC) ❑ No previous skin cancer ❑ Other: _____ Additional history: _____

Past Medical History(Please check all that apply)

❑Anxiety
❑Arthritis
❑Asthma
❑Atrial Fibrillation
❑Bone Marrow Transplantation
❑Breast Cancer
❑Colon Cancer
❑COPD
❑High Cholesterol
❑Coronary Artery Disease
❑Depression
❑Diabetes
❑End Stage Renal Disease
❑GERD
❑Hearing Loss
❑Hepatitis
❑High Blood Pressure
❑HIV / AIDS
❑Thyroid Problems
❑Leukemia
❑Lung Cancer
❑Radiation Treatment
❑Seizures
❑Stroke
❑NONE
❑Other Medical History not specified: _____
_____
_____

Past Surgical History (Please check all that apply)

❑Appendix Removed
❑Bladder Removed
❑Mastectomy (Right, Left, Bilateral)
❑Lumpectomy (Right, Left, Bilateral)
❑Breast Biopsy (Right, Left, Bilateral)
❑Breast Reduction
❑Breast Implants
❑Colectomy: Colon Cancer Resection
❑Colectomy: Diverticulitis
❑Colectomy: IBD
❑Gallbladder Removed
❑Coronary Artery Bypass
❑Mechanical Valve Replacement
❑Biologic Valve Replacement
❑Heart Transplant
❑Testicles Removed (Right, Left Bilateral)
❑Prostate Biopsy
❑Prostate Removed: Prostate Cancer
❑TURP: Prostate Removal
❑Hysterectomy: Fibroids
❑Hysterectomy: Uterine Cancer
❑Joint Replacement, Knee (Right, Left, Bilateral)
❑Joint Replacement, Hip (Right, Left, Bilateral)
❑Joint Replacement (last 2 years)
❑Kidney Biopsy (Nephrectomy)
❑Kidney Removal (Right, Left)
❑Kidney Stone Removal ❑Kidney Transplant
❑Ovaries Removed: Endometriosis
❑Ovaries Removed: Ovarian Cancer
❑Ovaries Removed: Cyst ❑Spleen Removed
❑NONE
Other Surgical not specified:
_____
_____
_____

Skin Disease History (Please check all that apply)

❑Acne
❑Actinic Keratosis
❑Asthma
❑Eczema
❑Flaking or Itchy Scalp
❑Hay Fever / Allergies
❑Melanoma
❑Poison Ivy
❑Precancerous Moles
❑Psoriasis
❑Blistering Sunburns
❑Dry Skin
❑NONE

Do you wear sunscreen? ❑ Yes ❑ No If yes, what SPF?: _____

How often? ❑ Daily ❑ When outside ❑ Occasionally ❑ Never

Do you tan in a tanning a tanning salon? ❑ Yes ❑ No

Alerts:

❑Allergy to Adhesive
❑Allergy to lidocaine
❑Allergy to topical antibiotics
❑Artificial heart valve
❑Blood thinners
❑Defibrillator
❑MRSA
❑Artificial joint replacement
❑Pacemaker
❑Require antibiotics prior to a surgical procedure
❑Rapid heartbeat with epinephrine
❑Are you pregnant or currently trying to get pregnant
❑NONE

What products do you use for your skin care routine?_____

_____

Facial cleanser: _____ Sunscreen: _____

Body wash: _____ Face/body moisturizer: _____

Shampoo/ conditioner: _____ Detergent/ Fabric softener: _____

Social History: ❑ Current smoker ❑ Former smoker ❑ Never smoked

Alcohol ❑Yes ❑ No _____ drinks/day _____ drinks/week _____ drinks/month

Caffeine ❑Yes ❑No Type _____ Amt per day _____

Non-prescribed drugs ❑ Yes ❑ No Type _____Amt per day _____

Request for Confidential Communication of Protected Health information

Patient name: _____ Date of Birth: _____

I give Dr. Samireh Said permission to release any information (appointments, results, treatment, and all questions) regarding my protected health to the following only (mother, father, husband, wife, etc)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Patient signature: _____ Date: _____

Regarding Laboratory Results

Dear Patient,

As your dermatologist, Dr. Samireh Said feels it is very important that you receive all laboratory results. It is standard procedure for our office to notify our patients by either phone or mail of their results. However, in the unlikely event that a laboratory result is not received by our office, standard procedure for notification of our patients may not take place. We therefore ask our patients to share responsibility of obtaining their laboratory results by calling for results if not notified within 2 weeks. Your physician Dr. Samireh Said will let you know during your visit what testing will be done so you are aware of what results are pending. Your health care is our number one priority. Thank you for partnering with us in your care.

Sincerely,
Dr. Samireh Said

✓ If my caller ID blocks Dr. Samireh Said's office phone number, I understand that you will not attempt to leave a message
✓ I will take responsibility for calling my lab results if not notified in a reasonable amount of time.

Patient signature: _____ Date: _____

Authorization to Leave Messages

I give my permission for the staff of Dr. Samireh Said's office to leave messages regarding my health care, prescriptions, normal test results, appointments, and authorizations.
If a family member answers the phone, I give Dr. Samireh Said's office permission to leave your name and phone number.

Patient signature: _____ Date: _____

Patient Financial Policy and signature on File

Patient name: _____ Date of Birth: _____
(please print LAST, FIRST)

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

Patient signature: _____ Date: _____

Consent to Medical Care & Treatment of Minor Children

I, _____, the natural parent/ legal guardian of

_____ _____
(Last name, first name) DOB

authorize and consent to medical and surgical care, treatment, and procedures to be performed for my child by a licensed physician/provider. In the sole discretion of the attending physician/provider, such care, treatment, and procedures are necessary or advisable in the interest of my child's health and well-being. This consent is valid until I have notified Dr. Said's office that this policy has been revoked.

_____ _____
Signature of parent/ guardian Date

Patient Partnership Plan

Dear patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. Achieving your best possible heath requires a “partnership” between you and your doctor. As our “Partner in Health”, we ask you to help us in the following ways:

Schedule visits with my doctor for routine physical exams and other recommended health screenings. I understand that Dr. Samireh Said will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete these recommended health screenings, tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam to discuss these health screenings.

Keep follow-up appointments and reschedule missed appointments. I understand that Dr. Samireh Said will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives her the chance to check my condition and my response to treatment. During a follow up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the office when I do not hear the results of labs and other tests. I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform Dr. Samireh Said if I decide NOT to follow her recommended treatment plan. I understand that after examining me, my doctor may make certain recommendations based on what she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that not following my treatment plan can have serious negative effects on my health. I will let my doctor know whether I decide not to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

Patient signature: _____ Date: _____

Patient name: _____ Date of Birth: _____

Dear Valued Patient,

With all the changes in Healthcare we feel the need to communicate the following information regarding your insurance health coverage:

1. Dr. Samireh Said's office does not quote or guarantee coverage for services provided by our practice.
2. Our office bills your insurance company as a courtesy on your behalf for services provided, however this does not imply you will have no out of pocket costs associated with your care.
3. Our office is legally bound by our PPO contracts to collect your co-pay at the tie service is rendered.
4. Our office provides a courtesy service of verifying your benefits and eligibility. We rely on the information provided by your insurance company to be current and complete, however we do not guarantee that the information provided by your insurance company is accurate.
5. Our office refers patients to facilities and/or laboratories, in which to the best of our knowledge, correspond to the patient's network. Ultimately, it is the patient's responsibility to know the plan coverage and limitations of their own health insurance policy.

We acknowledge that dealing with Healthcare coverage issues can be confusing as well as frustrating. Our office makes every attempt to verify the specifics of your coverage, however, as physicians specializing in your healthcare needs, any assistance our office provides to obtain insurance information is simply as a courtesy and not an obligation.

We thank you in advance for understanding our role in your Healthcare. We invite you to partner by obtaining your individual insurance plan coverage specifics prior to receiving services with our office.

Thank you kindly for your cooperation in this matter.

Medicare: We are participating providers of the Medicare program. Patients are responsible for meeting their annual $110.00 deductible and paying for the 20% co-payment. We do file with secondary/ supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balanced billed. If you have medi-cal or a HMO as a secondary, the balance after medicare pays is your responsibility.

PPO or other managed care patients: You will be responsible for paying your annual deductible, copayment, coinsurance , and charges for any non-covered, cosmetic services.

MEDI-CAL and HMOs: Dr. Said will not accept any kind of HMO or Medi-cal insurance as a primary or secondary plan. You will be considered a cash patient and the entire balance is due at the time of service or after your primary insurance has paid.

Commerical patients: patients who are covered by private, commercial plans in which the physician they are seeing is not a provider will be required to pay 35% of the total bill at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient signature: _____ Date: _____

Patient name: _____ Date of Birth: _____

Medicare Patients Only

The office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration 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 th original, and request payment of medical insurance benefits either to myself or the part who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on Medicare Card Date

Prior Authorization Policy

As your physician we make every effort to ensure that you receive the safest, most effective and reasonably priced prescription drugs, treatments, laboratory tests, and imaging studies we feel is best suited for your healthcare. We must also abide by regulations set by your insurance companies and government agencies. Over the last year, many health insurance companies or plans are requiring Prior Authorization or approval for an increasing number of drugs, treatments, imagining studies and laboratory tests.

As this is an additional and labor-intensive service our staff completes, Dr. Samireh Said will begin charging a fee of $25.00 per authorization fee for medications. This cost is an out-of-pocket expense to you and is not covered by insurance. You can be assured that your provider will take every step necessary to provide you with cost effect treatments and alternatives. We will fully evaluate your medical needs, and if appropriate, recommend a medication that does not require prior authorization. Prior Authorizations for drugs required as a result of telephone requests from patients will always be charged a $25.00 fee

Please note: This still does not guarantee approval from your insurance company. Please feel free to contact our office at (714) 669-0844 with any questions.

Patient signature: _____ Date: _____

Patient name: _____ Date of Birth: _____

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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