California Dermatology Care- Dr. William Ting, MD Board Certified Dermatologist

2262 Camino Ramon Ste 200, San Ramon CA 94583
Tel: (925) 328-0255 Fax: (925) 328-0257 www.CalDermCare.com

Thank you for choosing our practice! We are committed to the success of your medical care and understand that payment of your bill is part of this care. Please read our policies below, ask us any questions you may have, and sign in the space provided. A copy of this policy will be provided to you upon request.

1. **Insurance**. We participate in most PPO insurance plans, including Medicare. If you are not insured by a plan we do business with, OR don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage. We must obtain a copy of your current valid insurance card yearly to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of any claim. ________(please initial)

2. **Co-Payments, Co-Insurance and Deductibles**. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company and you will also be responsibility for any co-insurance and deductibles for your visit. **Failure to make a required co-payment on the day of the service will result in an additional administrative surcharge of $20.00.** ________(please initial)
3. **Non-covered or cosmetic services**. Cosmetic consultations, laser surgery, cosmetic fillers like Restylane and Radiesse, Botox and cosmetic mole removal and related cosmetic services must be paid in full prior to the visit. You may or may not use flexible spending account (FSA) for cosmetic related services depending on your FSA policy. Please check with your FSA administrator prior to using the account for payment. ________(please initial)

4. **Patients without health insurance.** Payment in full is required prior to your appointment. If the total cost of your visit is not absolutely determined, you will be asked to make an estimated payment and the differences will be recalculated upon the completion of the appointment. ________(please initial)

5. **Claim submission.** We will bill your health insurance company directly. **Please be aware that the balance of your claim including co-insurance and deductible is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. ________(please initial)

6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. ________(please initial)

7. **Nonpayment.** Accounts that are repeatedly ignored will be sent to collections. ________(please initial)

8. **Missed Appointments.** As a courtesy, our clinic utilizes **Televox house call reminder system** to send out phone/email reminders two days prior to the appointment date. **Please confirm the appointment when you receive the reminder call**. If you need to reschedule or cancel the appointment, please follow the prompt to leave our staff a message so we can follow up your request in a timely fashion. Please understand that when you do not cancel an appointment you are unable to keep, it prevents other patients from receiving care they need. **Therefore, our policy is to charge $25 for missed appointments not cancelled within 24 hours of the appointment time. Missed surgery or cosmetic appointments will be charged $150.** ________(please initial)

9. **Bounced Checks.** If a check is returned to our office for insufficient funds, or if payment has been stopped, you will be charged a fee of $50. _________(please initial)

10. **Credit Card Policy.** We accept Visa, Master, and Discovery cards. In the event that you request to use a different card (including FSA card) after the credit card has been settled, there will be a 5% processing charge apply to the new transaction. _________(please initial)

11. **Cancer policy, disability, camp or other medical forms.** If you request that the physician fill out a form of this type, there will be a $45 fee. _________(please initial)

12. **Skin care products** may be returned within 30 days of purchase. A 5% restocking fee will be charged to all returns and the refunds will generally be in the same form of payment via credit card or check and be processed within 7 business days. No refunds will be issued after 30 days of purchase. **Prescription items are non-refundable.** _________(please initial)

13. **Light box phototherapy. Patients receiving phototherapy or Excimer Laser are advised to contact their insurance company to find out their responsibility for co-pays, co-insurance and deductibles.** _________(please initial)

14. **May we e-mail or mail practice promotional information to you?** ☐ Yes ☐ No

    Email Address:____

Our medical insurance billing is performed by the billing office of Dermatology Associates of the Bay Area at the Hercules Location. If any questions arise with regard to your insurance billing, you may call our billing department at 510-741-7299 Monday –Friday 8:00 am to 5:00 pm.

I have read and understand the payment policy and agree to abide by its guidelines; I have also received a copy of HIPPA Notice of Privacy Practice and understand the information contained in the document:

____ ____________________

Signature of patient or responsibility party **Date**

____

Printed Name (Patient name if minor)

PATIENT INFORMATION ❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ___/___/___

Name ____
Last *First* *M.I.*

Date of Birth: ___/___/___ Age: _____ Social Security #____________________ Sex: ❑ Male ❑ Female

ADDRESS:

Mailing Address ____
City *State* *Zip*

Home Phone: ( )__________________ Work Phone: ( )__________________

Cell Phone: ( )__________________ e-mail: __________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: ______________________________________ Date of Birth: ___/___/___
Last *First* *M.I.*

Address: ____
City *State* *Zip*

Home Phone: ( )__________________ Work Phone: ( )__________________

INSURANCE COVERAGE - <u>PRIMARY:</u>

Insurance Co. Name:__________________ Phone: ( )__________________ Ext:______

Address of Claim Center:____

____
City *State* *Zip Code*

Name of Policy Holder (Insured):______________________________

Policy Holder (Insured) Date of Birth: ___/___/___ SS#__________________ Sex: ❑ Male ❑ Female

Policy #:__________________ Group Name or #:__________________

Policy Type: ❑ HMO ❑ PPO

Employer Name: ____

Employer Address: ____

If patient is child, check relationship: ❑ Mother ❑ Father ❑ Other__________________

INSURANCE COVERAGE - <u>SECONDARY:</u>

Insurance Co. Name:__________________ Phone: ( )__________________ Ext:______

Address of Claim Center:____

____
City *State* *Zip Code*

Name of Policy Holder (Insured):______________________________

Policy Holder (Insured) Date of Birth: ___/___/___ SS#__________________ Sex: ❑ Male ❑ Female

Policy #:__________________ Group Name or #:__________________

Policy Type: ❑ HMO ❑ PPO

Employer Name: ____

Employer Address: ____

If patient is child, check relationship: ❑ Mother ❑ Father ❑ Other__________________

ATTACH A COPY OF PATIENT'S INSURANCE CARD (BOTH SIDES)

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name:______________________________________ Today's Date ____/____/____

Other family members that are patients ____

Referred by: ____

Primary Care Physician ______________________ Phone (   )______________

EMERGENCY CONTACT INFORMATION:

In case of mergency, who should be notified?_________________ Phone (   )______________

Do you give our office permission to discuss your medical information with family members?

❑ YES ❑ NO If yes, please provide their names and phone numbers below.

Name: ____________________________ Relationship: ____________________

Phone # (day): (_____)______________ Phone # (evening): (_____)______________

May we leave personal medical information on your answering machine at home?

❑ YES ❑ NO

May we e-mail personal medical information to you?

❑ YES ❑ NO E-mail address: ______________________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature ___________________________ Date ____/____/____

PAYMENT POLICY:

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

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35% of the total bill at the time of the 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 or Responsible Party Signature ___________________________ Date ____/____/____

Advanced Dermatology Care Inc.
Dr. William Ting, MD

Notice of Privacy Practice

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Our Commitment To Your Privacy

Advanced Dermatology Care Inc. is dedicated to maintaining the privacy of your health care information known as **Protected Health Information or PHI**.

This Notice describes our privacy practices, your legal rights, and lets you know, how Advanced Dermatology Care Inc. is permitted to

- o Use and disclose PHI about you
- o How you can access and copy that information
- o How you may request amendment of that information
- o How you may request restrictions on our use and disclosure of your PHI. In most situations we may use this information described in this Notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

B. If you have any questions about the notice, please contact:

Dr. William Ting, MD. 5801 Norris Canyon Rd, Ste 200-B, San Ramon, CA 94583

Purpose of this Notice: This Notice describes your legal rights, advises you of our privacy practices, and lets you know Advanced Dermatology Care Inc. is permitted to use and disclose Protected Health Information (PHI) about you.

C. Uses and Disclosures of PHI:

Advanced Dermatology Care may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

For treatment. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For payment. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

For health care operations. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

D. Use and Disclosure of PHI Without Your Authorization.

Advanced Dermatology Care Inc. is permitted to use PHI *without* your written authorization, or opportunity to object in certain situations, including:

- For Advanced Dermatology Care Inc. 's use in treating you or in obtaining payment for services provided to you or in other health care operations;
- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew;
- To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure

to a possible communicable disease as required by law;

- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law;
- We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization, (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). **You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information based upon that authorization.**

E. Patient Rights:

As a patient, you have a number of rights with respect to the protection of your PHI, including:

The right to access, copy or inspect your PHI. This means you may come to our offices and inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.

We have forms available for you to request access to your PHI. We will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical information, you should contact the privacy officer liaison listed at the end of this Notice.

The right to amend your PHI. *The right to request amending your PHI.* You have the right to ask us to amend written medical information that we may have about you. If errors are found, we will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information, but only in certain circumstances. For example, if we believe the information is correct and no errors exist, your request will be denied. If you wish to request that we amend the medical information that we have about you, you should contact in writing Dr. William Ting, MD.

The right to request an accounting of our use and disclosure of your PHI.

You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, such as our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting of the medical information about you that we have used or disclosed that is not exempted from the accounting requirement, you should contact the privacy officer listed at the end of this Notice.

The right to request that we restrict the uses and disclosures of your PHI. You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, if you request a restriction and the information you asked us to restrict is needed to provide you with emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment. Advanced Dermatology Care Inc. is not required to agree to any restrictions you request, but any restrictions agreed to by Advanced Dermatology Care Inc. are binding on Advance Dermatology Care Inc.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request. If we maintain a web site, we will prominently post a copy of this Notice on our web site and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Advanced Dermatology Care Inc.
Dr. William Ting, MD, 5801 Norris Canyon Rd, Ste 200-B, San Ramon, CA 94583.

Effective Date of the Notice:
05/24/2010