Howard L. Sofen, M.D.

PATIENT INFORMATION

NAME:		BIRTH DATE:	SEX: ☐ Female ☐ Male	SOCIAL SECURITY NO.:
ADDRESS:	APT:	CITY:		STATE / ZIP CODE:
PRIMARY PHONE: ☐ Cell ☐ Home ☐ Work	SECONDARY PHONE: ☐ Cell ☐ Home ☐ Work			REFERRED BY:
EMPLOYER:	EMAIL ADDRESS:			MARITAL STATUS: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

OTHER CONTACTS

Emergency Contact	NAME:	RELATIONSHIP:	PHONE:
Responsible Party	NAME:	RELATIONSHIP:	PHONE:
	ADDRESS:	CITY:	STATE / ZIP CODE:

INSURANCE INFORMATION

Primary	COMPANY NAME:	TYPE:	ID NO:
	INSURED'S NAME:	RELATIONSHIP:	GROUP NO:
Secondary	COMPANY NAME:	TYPE:	ID NO:
	INSURED'S NAME:	RELATIONSHIP:	GROUP NO:

PATIENT PRIVACY INFORMATION

I hereby authorize Howard Sofen and staff to communicate medical information pertaining to my care through the following methods: ☐ Cell phone ☐ Work Phone ☐ Home phone ☐ Email

I hereby authorize Howard Sofen and staff to communicate medical information pertaining to my care to a referred or referring healthcare provider. I assume responsibility to notify the office should any of this information change in the future.

_____
Signature

Please list the names of people, if any, our staff can discuss your medical care with:

NAME:	PHONE:	NAME:	PHONE:

I acknowledge that the above information is true and correct.

_____ _____
Signature Date

Howard L. Sofen, M.D.

Office Policies

PAYMENT POLICY

- All copayments and deductibles are due at the time of service. All previous balances must be cleared at the time of service.
- Patients are responsible for paying all balances not paid by the insurance carrier.
- We accept cash, checks, and credit cards (MasterCard, Visa, and American Express) for all payments. ATMs are accessible next door or across Sepulveda Blvd.
- If insurance coverage has been terminated prior to the time of service, patients are responsible for all charges incurred.
- All balances owed by patients which are not paid after 120 days will be sent to collection.
- A $25.00 fee will be imposed for returned checks. Payment must be made within 10 days to avoid collection's actions.

HMO PATIENTS

- Patients are responsible for obtaining and bringing proper authorization *prior* to their visit.
- HMO insurance will not cover your visit without appropriate authorization. If no authorization is present, patients can be seen on a cash basis, but will not be reimbursed for the charges.

MEDICAL NECESSITY

- If the insurance carrier determines that a particular service is not medically necessary under their policy guidelines, they will deny payment for that service.
- The criteria for medical necessity are at the discretion of the insurance carrier and can change at any time.
- Patients are responsible for verifying coverage with their insurance carrier. Our staff can only give general information about what is *usually* covered by most carriers.
- The care your provider believes is medically necessary may not be considered a medical necessity or may not be a covered benefit under your plan.

APPOINTMENTS

- If you are unable to make an appointment at your scheduled time, please advise us at least 24 hours in advance. We will assist you with a reminder call on the day before your appointment.
- While we understand that unforeseen circumstances may require a last minute cancellation/postponement, we reserve the right to charge for missed appointments or appointments cancelled with insufficient notice.
- We reserve the right to refuse to schedule an appointment for any patient after three failures to adhere to these policies.

_____ _____

Signature Date

Privacy Policies

Our practices' Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. A copy is available at the front desk. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you acknowledge that you have been given the opportunity to review our Notice of Privacy Practices and you consent to our use and disclosure of protected health information about you for treatment, payment from your insurance company, and health care operations. You have the right to revoke this consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

_____ _____

Signature Date

Howard L. Sofen, M.D.

MEDICAL HISTORY

REFERRING DOCTOR:	PHONE NUMBER:	FAX NUMBER:

Do you have a pacemaker or defibrillator?	Yes ☐	Do you or have you ever used a tanning bed?	Yes ☐
Have you ever had a sunburn?	Yes ☐	Do you use sunscreen?	Yes ☐

Have you been diagnosed with…? (If you do not have ANY, mark "NONE of these")

Emphysema/COPD	Yes ☐	Fainting	Yes ☐	HIV / AIDS	Yes ☐
Asthma	Yes ☐	Hepatitis A, B, C	Yes ☐	Lupus	Yes ☐
Depression or Anxiety	Yes ☐	Stroke	Yes ☐	Convulsions, seizures, epilepsy	Yes ☐
Seasonal allergies / Hay fever	Yes ☐	Diabetes	Yes ☐	Cancer (Type:)	Yes ☐
High blood pressure	Yes ☐	Thyroid Disease	Yes ☐	Joint replacement	Yes ☐
Heart failure	Yes ☐	Kidney disease / failure	Yes ☐	History of blood transfusion	Yes ☐
Heart attack	Yes ☐	Arthritis	Yes ☐	Artificial heart valves or joints	Yes ☐
Mitral valve prolapse	Yes ☐	Liver disease	Yes ☐	**NONE of these**	☐

MEDICATIONS

CURRENT MEDICATIONS:	ALLERGIES TO MEDICATIONS:

Have you ever had a reaction to Novocaine, Lidocaine, bandages, latex, or topical antibiotics? **Please describe.**

DERMATOLOGICAL HISTORY

Do YOU have a history of.? (If you do not have ANY, mark "NONE")		**Does your FAMILY have a history of…?** (If you do not have ANY…)	
Melanoma	Yes ☐	Melanoma	Yes ☐
Atypical / Dysplastic Moles	Yes ☐	Atypical / Dysplastic Moles	Yes ☐
Squamous Cell Carcinoma	Yes ☐	Squamous Cell Carcinoma	Yes ☐
Basal Cell Carcinoma	Yes ☐	Basal Cell Carcinoma	Yes ☐
Actinic Keratoses	Yes ☐	Actinic Keratoses	Yes ☐
History of keloids / scarring	Yes ☐	History of keloids / scarring	Yes ☐
Psoriasis	Yes ☐	Psoriasis	Yes ☐
Eczema	Yes ☐	Eczema	Yes ☐
Hives	Yes ☐	Hives	Yes ☐
NONE of these	☐	NONE of these	☐

REVIEW OF SYSTEMS

Please describe any other symptoms you have been suffering from:

Howard L. Sofen, M.D.

8930 South Sepulveda Boulevard
Los Angeles, California 90045

(310) 337-7171
Fax (310) 337-1081

Notice of Privacy Practices

Effective date of this notice: 9/1/2010

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your identifiable health information.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time of your visit.

The terms of this notice apply to all records containing your IIHI that are created or retained in our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. A copy of our current Notice is available upon request and online at drsofen.com.

USE AND DISCLOSES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. These include:

Treatment. We may use and disclose your IIHI to a physician or other healthcare provider providing treatment to you.

Payment. We may use and disclose your IIHI to obtain payment for the services we provide to you.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities; reviewing the competence or qualifications of healthcare professionals; evaluating practitioner and provider performance; conducting training programs, accreditation, certification, licensing or credentialing activities.

To Your Family/Friends. We may disclose your IIHI to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only with your permission.

To Persons Involved In Care. We may use or disclose your IIHI to notify (or assist in the notification of) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, you will be given opportunity to object to such uses or disclosures. In the event of your incapacity or in an emergency, we will use our professional judgment to determine the health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services. We will not use your IIHI for marketing without your written authorization.

Required by Law. We may use or disclose your health information when we are required to do so by federal, state, or local law. This could include health oversight activities, public health risks, or upon request of a law enforcement official.

Abuse or Neglect. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or custodial law enforcement officials the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders. We may use or disclose your IIHI to provide you with appointment reminders.

PATIENT RIGHTS

You have the following rights regarding the IIHI that we maintain about you:

Access. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing and indicate the format you wish to receive. We will use the format you request unless we cannot practicably do so. We may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. We may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct such reviews.

Confidential Communications. You have the right to request that our practice communicate with you about your health information by alternative means or to alternative locations. (For instance, you may ask that we contact you at work rather than home.) You must make a written request specifying the preferred method of contact, or the location where you wish to be contacted. We will accommodate *reasonable* requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your health information. We are not required to agree to these additional restrictions; however, if we do agree, we are bound by our agreement except in emergencies, when otherwise required by law, or when the information is necessary for treatment. You must make a written request specifying the information you wish restricted, whether you are requesting to limit our practice's use or disclosure or both, and whom you want the limits to apply to.

Disclosure Accounting. You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Amendment. You have the right to request that we amend your health information. You must make a written request indicating the changes and reason for the amendment. We may deny your request under certain circumstances.

Paper Notice. If you receive this notice on our website or by e-mail, you are entitled to receive this notice on paper.

QUESTIONS AND COMPLAINTS

If you have any questions regarding this notice or our health information privacy policies please contact us.

If you believe your privacy rights have been violated or if you disagree with a decision we made about access to your health information, or if you disagree with our response to a request for amendment of these terms, you may file a complaint to the office personnel indicated below. You may also submit a written complaint to the U.S. Department of Health and Human Services and we can provide you with the necessary address upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: **Jacqueline O'Toole**

Telephone: **(310) 337-7171** Fax: **(310) 337-1081**

Email: **jotoole@drsofen.com**

Address: **8930 S. Sepulveda Blvd., Ste. 114, Los Angeles, CA 90045**

Howard L. Sofen, M.D.

Dermatology

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Los Angeles, California 90045

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Consent to Treat Unaccompanied Minor

It may be convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal decision maker cannot be present prior to treatment. Be advised that protected health information may be shared with the designated decision maker to facilitate informed decision making.

AUTHORIZATION

I have the legal right to preauthorize Howard Sofen and Associates to treat my child/ward and I give permission to Howard Sofen and Associates to treat my child/ward to treat my child/ward for the indicated conditions over the indicated period. This authorization is valid until revoked in writing.

_____ _____
Patient's Name Date of Birth

LIMITATIONS

This authorization is restricted in the following ways (mark all that apply):

☐ **Conditions:** _____
Howard Sofen and Associates can only treat the above indicated conditions.

☐ **Dates:** _____ to _____
Howard Sofen and Associates can only provide treatment between these dates.

☐ **Procedures:** _____
Howard Sofen and Associates can only perform the above indicated procedures.

EMERGENCY CONTACT

If urgent medical care is needed, first try to contact me regarding the health care of my child at the following numbers. If you are unable for any reason to contact me, then you may rely on the designated decision maker for consent.

_____	_____	_____
Contact Name	Primary Phone	Secondary Phone
_____	_____	_____
Contact Name	Primary Phone	Secondary Phone

_____ _____
Parent/Guardian Signature Date