

Patient Information

Name _____
Last First MI

Home # _____ Cell # _____

Home Address _____

_____ City State ZIP

Male Female Age _____ Birth Date _____

Single Married Divorced Widowed

E-mail _____

Can we email you? Yes No

Social Security Number _____

Referred to Our Office by _____

Occupation _____ Employer _____

Pharmacy _____ Phone _____

Spouse or Parent Information

Name _____ Phone _____

Person to Call In Case of Emergency

Name _____ Phone _____

Medical History

Please check **yes** or **no** then circle all that apply
Yes No

Melanoma: Personal and/or Family History?

Do YOU have a Personal History of the following?

Basal Cell or Squamous Cell Carcinoma

Excessive Bleeding from Cuts or Surgery

History of Skin Infections or MRSA

Have you ever fainted or almost fainted

Asthma, Hayfever, Eczema

Heart Disease or Irregular Heart Beats

High Blood Pressure

Cardiac Pacemaker or Artificial Joint

Hepatitis/Liver Disease

Diabetes, Kidney or Thyroid Disease

HIV Infection or AIDS

Do you Smoke or Use Tobacco Products

Comments: _____

Medical History (continued)

Current and/or Past Medical Conditions: _____

List Previous Surgeries: _____

Medication Allergies (please put NONE if no Med allergies):
 Allergies: _____
 What Happens: _____

Name of Primary Insurance Company

Insurance Co. Name: _____

Insured Person / Financially Responsible Party

Primary Insured Person: (Check One)

Patient (if patient skip this section) Spouse Parent Other

Name _____
Last First MI

Home # _____ Soc Sec # _____

Birth Date _____ Age _____ Male Female

Employer _____ Work# _____

Home Address: _____

_____ City State ZIP

Do you have **Secondary Insurance?** Yes No
 If **YES, Who Is The Primary On The Secondary Insurance?**
 Name _____ Date of Birth _____

Consent: Treatments, Photos & Assignment of Benefits

I give my consent for examination, treatment, biopsy &/or excision, and the exchange of medical information for purposes of medical treatment & second opinions. I hereby assign all medical benefits to Jeffrey Klein, MD, Inc. I am financially responsible for all charges incurred, whether or not paid by insurance. I authorize the release of medical information to my insurance carrier I have received a copy of the Notice of Privacy Practices. I agree to be charged \$25 no-show/cancellation fee if I miss an appointment without notifying the office at least 24 hours prior to my appointment. I attest that the information I provided on this form is correct.

Yes No I consent to be photographed for teaching, research, publications & online marketing.

 Signature Date

Below is for Review & Updates (Please Date & Initial)

Initial _____ Date _____

Dr. Jeffrey A. Klein, Inc. Notice of Privacy Practices. 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.

Uses and Disclosures of your medical information (HIPAA): **Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members. **Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. **Health care operations.** Your health information may be used as necessary to support the day-to-day activities and management of Dr. Jeffrey A. Klein, Inc. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality. **Law enforcement.** Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting. **Public health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department. Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. Additional uses of information include: **Appointment reminders.** Your health information will be used by our staff to send you appointment reminders. **Information about treatments.** Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you. **Individual Rights.** You have certain rights under the federal privacy standards. These include: The right to request restrictions on the use and disclosure of your protected health information The right to receive confidential communications concerning your medical condition and treatment The right to inspect and copy your protected health information The right to amend or submit corrections to your protected health information The right to receive an accounting of how and to whom your protected health information has been disclosed The right to receive a printed copy of this notice. **Dr. Jeffrey A. Klein, Inc. Duties:** We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice. **Right to Revise Privacy Practices:** As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. **Requests to Inspect Protected Health Information:** As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Dr. Jeffrey A. Klein. **Complaints:** If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to: Dr. Jeffrey A. Klein, Inc., 30280 Rancho Viejo Road, San Juan Capistrano, CA 92675. Telephone (949) 248-1632. If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint. You can contact Jeffrey A. Klein, MD, for further information concerning our privacy practices. **Effective Date:** This Notice is effective on or after September 11, 2002.

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS INFORMATION

EXPLANATION: _____

PATIENT NAME: _____ Birthdate: _____

Treatment Date(s): _____

INFORMATION TO BE RELEASED FROM:

Jeffrey Alan Klein, M.D.
30280 Rancho Viejo Road
San Juan Capistrano, CA 92675
TEL: (949) 248-1632

INFORMATION TO BE RELEASED TO:

NAME/AGENCY: _____

ADDRESS: _____

PURPOSE FOR RELEASE: _____

INFORMATION TO BE RELEASED:

- (1) Clinical progress notes
- (2) Lab reports
- (3) Surgical procedure notes

Other (specify) _____

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 19 81, Section 56 et seq., California Civil Code.

This authorization is effective immediately and is subject to revocation at any time, except to the extent that action has already been taken. Otherwise, this authorization expires ____ days from the date of SIGNING.

I am aware of and/or have been advised of the provisions of existing State and Federal Statutes, Rules and Regulations which provide for my right to confidentiality of the information in this records. I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records can be released, and that I may refuse to sign, but in that event the records cannot be released. I further release my attending physician, consultants, the facility and employees from any liability arising from the release of information to the person(s)/agency designated above. I understand that I have a right to receive a copy of this authorization upon my request.

*A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a non-profit hospital plan, a health care service plan or an employee benefit plan.

DATE: _____ DATE: _____

SIGNATURE OF PATIENT/GUARDIAN/REPRESENTATIVE

SIGNATURE OF PATIENT