Dr. Jeffrey Klein Dermatology Patient Information Record (PIR) 180712

Jeffrey A. Klein MD, Norma Kassardjian MD, Kristen Aguirre MD, Atoussa Cameron NP, Jo-Ann Coker NP
30280 Rancho Viejo Road, San Juan Capistrano, CA 92675 Tel 949-248-1632 Fax 949-248-9339

Patient Information

Name_____
Last First MI

Age____ Birth Date_____ ☐Male ☐Female

Home #_____Cell #_____

Home Address_____

_____
City State ZIP

☐Single ☐Married ☐Divorced ☐ Widowed

E-mail_____

Can we email you? ☐ Yes ☐ No

Last 4 Digits of 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 **&/or** Family History?

Do YOU have a History of 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, Hay fever, 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 photographs for teaching, research, publications & online marketing. Personal ID will be protected.

_____ _____
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.

HK Dermatology Group

Jeffrey Klein MD, Norma Kassardjian MD, Kristen Aguirre MD, Atoussa Cameron NP, JoAnn Coker NP

Medication Flow Sheet 180413

Patient Name				DOB	Ht & Wt	
Date	Reviewed & Initialed	Medication	Indication or Purpose of Drug	Dose & Frequency	Adverse Effects or Allergies	Recent Wt Change?

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**