COSMETIC DERMATOLOGY
OF ORANGE COUNTY

New Patient Welcome Packet

Dear New Patient:

It is with great pleasure that we welcome you to Cosmetic Dermatology of Orange County. We take pride in providing patients with contemporary clinical, surgical and cosmetic dermatologic services since 1980. Through our two offices, we provide convenient, best-practice treatments and regimens by experienced, highly specialized licensed medical physicians, physician's assistants and specialty trained nursing staff.

Cheryl L. Effron, M.D., Founder and Medical Director, is renowned as a leading authority on dermatologic care and procedures. She has lectured and trained doctors worldwide on her treatments and product protocols. She has earned the reputation of being one of the best and most sought-after physicians in her specialty within Orange County.

At Cosmetic Dermatology of Orange County, you will enjoy the latest, state-of-the-art technology coupled with personalized service. We offer comprehensive cosmetic and aesthetic services beyond our clinical care to ensure that you look and feel your absolute best. Our mission and the passion of our physicians is to improve your skin to its fullest potential and to "make you more naturally beautiful."

This packet will provide you with everything you need for your first visit. However, if you have any questions that are unanswered, please feel free to contact one of my specialist at either offices.

Wishing you good health,

Cheryl L. Effron, M.D., F.A.A.D

COSMETIC DERMATOLOGY of ORANGE COUNTY
Important Information

Locations

We offer two convenient locations for your appointments:

Anaheim Hills (click for directions)
500 S. Anaheim HIlls Rd #210
Anaheim, CA 92807
714-974-3272
714-974-4517 - fax

Huntington Beach (click for directions)
17822 Beach Blvd #452
Huntington Beach, CA 92647
714-848-5851
714-848-9801 - fax

Appointment Reminders

Our automated system will call you with a personalized reminder of your appointments approximately 48 hours in advance of your scheduled appointment. Please note that there is a patient response requested at the end of the reminder so we can confirm your intension.

Website - www.laserdermdoc.com

Our website contains information about the practice, practitioners, procedures, new products and monthly procedure and product sales. Additionally, our WEB STORE offers our skincare items that can be delivered directly to your home or office. Shipping is free for orders greater than $100. USPS Priority will deliver these items to your address within 1-2 day (for Southern California residents). Our blog offers medical and cosmetic information for your education.

Fragrance Free Environment

Due to the sensitivity of our patients and staff, we respectfully request that you refrain from wearing perfumes, scented oils, colognes or anything of fragrance to our offices.

First Visit

Your first visit will be greatly expedited by having the following paperwork completed prior to your arrival. Also, please note that we require copies of the front and back of your insurance cards be sent to the office 48 hours in advance of your appointment. This will allow us to verify your coverage. Insurance card copies and details can be faxed to 714-974-4517 or emailed to office@laserdermdoc.com.

Late Arrival & Failure to show

Please note that we strive to appropriately schedule each patient for the time necessary for their evaluation or procedure. If you are going to be late for your appointment, please call our office in advance to allow us to determine if you need to be rescheduled.

The pages that follow will further familiarize you with our Practice Policies and Guidelines, then will proceed into the documentation we need for the establishment of your medical records. If you have any questions about this paperwork, do not hesitate to call one of the specialists in the office for guidance.

COSMETIC DERMATOLOGY of ORANGE COUNTY
Patient Policies and Guidelines

We provide these policies and guidelines with the intention of improving your patient experience in our offices. Please review and feel free to ask questions of any staff member upon your arrival.

Medical Insurance:

We accept several PPO Insurance policies and with applicable coverage, will bill your insurance carrier on your behalf after your visit. However, to ensure that we have the opportunity to verify your benefits, we request that you submit all of your insurance details, including copies of the front and back of your insurance cards, to our office 72 hours prior to your visit. If we are unable to receive the necessary information to verify your eligibility and benefits, we will still be happy to see you on a cash basis and will provide you the forms to submit to your carrier for personal reimbursement. Insurance details can be emailed to office@laserdermdoc.com or faxed to 714-974-4517. Please note that verification of eligibility and benefits is not a guarantee of payment by your carrier. It is your responsibility to rectify Insurance non-payment issues with the carrier.

Billing of Balance Due:

Upon receipt of payment and an explanation of benefits from your insurance carrier, there may remain a balance for the services provided. This balance can be due to either your deductible for a plan year not having been met or a co-insurance percentage that your carrier requires of you to pay. These statements will be mailed to the address that we have on record for you and are due immediately upon receipt. Balances that are not paid in full will be charged an additional $25.00 fee per cycle. Payment can be taken by staff over the phone by simply calling either practice location.

Payment for Services Rendered:

Co-payments, deductibles, co-insurances and all cosmetic procedure costs are due at the time that services are rendered. If payment is not made at the time services are rendered, a billing fee of $25.00 will be assessed to your account. If your account has to be turned over to collections for non-payment, a $50.00 fee will be assessed

Medical Necessity:

Many growths that you may consider unsightly or annoying do not jeopardize your health and are thus not considered a "Medical Necessity" for removal. This might include a mole that is in a conspicuous spot or a birthmark that is visible outside of normal clothing. Items that fall into this category are considered to be Cosmetic Procedures and therefore will not be covered by insurance plans. You will be provided a written estimate of fees due for the procedure that will be due on the date of the procedure.

NSF Check Fee:

If your payment by check is returned from your bank for Non-sufficient funds, we will access a $50.00 fee which will have to be paid prior to your being rescheduled in our office. That fee and the balance of the check will need to be paid by cash, money order, cashier's check or credit card.

Arrival for appointments:

We appreciate your timely arrival for your appointment. In circumstances that you simply cannot make it by the established time, please understand that we will work you back into the schedule as quickly as possible. It is always best to call the office, even if you are going to be 5 minutes late as we may be required to reschedule your appointment.

Cosmetic Procedures (injectables, fillers, lasers, etc):

Cosmetic procedures are considered to be "elective" by insurance carriers; therefore these procedures are not covered by insurance plans. We require a deposit of $50.00 to schedule these appointments. The deposit can apply to the cost of your procedure at checkout. Alternatively, the deposit can be left on account for cosmetic procedures scheduled in the future. The CO2 SmartSkin laser procedure will require a $200.00 deposit due to the one-hour block of time required to complete the procedure. This deposit can also apply to the cost of the procedure. If you elect a Sculptra Aesthetic injectable filler, the entire fee for that procedure will be required in full one week in advance of the procedure due to the advanced preparation time of the material.

Temperature in office:

We recognize that the temperature in our offices may seem cool to the average patient. This is due to the state-of-the-art laser equipment that we have in many of our practice rooms and the heat that is generated by that equipment. Please dress accordingly and ask a nurse if you need a blanket while you wait. One will gladly be provided.

Appointment Reminders:

You will be contacted between approximately 48 hours in advance of your appointment by our system to confirm your appointment. This confirmation may be issued by phone call, e-mail or text (SMS). Please note that there is a patient confirmation requested at the end of the call so we can confirm your intention.

Families:

We welcome families in our practice but due to limitations on space in our waiting room and procedure rooms, we kindly request that only family members with appointments or parents of youth with appointments come to the office. This ensures that other patients have a comfortable place to wait for their appointment time.

Validation of Parking (Anaheim Hills only):

We validate the parking of all of our patients in the Anaheim Hills office that are in the office more than 15 minutes. Validation will be provided at time of check-out.

Quotes for Procedures:

With any procedural evaluation, you will receive a quote that is noted in your patient chart for services that are recommended to you, whether cosmetic, medical or surgical in nature. These quotes are good for 6-month from the date of your evaluation. After 6 months, the quote is invalidated due to the fact that the condition/issue may have changed or progressed, requiring more extensive treatments or repairs.

Fragrance-Free Environment:

Due to sensitivity of our doctor, staff and many of our patients, we kindly request that you refrain from the use of any types of perfume, body oils, scented body washes, etc. These can cause allergies and asthma to flair resulting in discomfort to those affected. Please understand that you may be asked to wash off fragrances before being seen.

Care Credit:

We offer Care Credit Beauty Card for the convenience of you financing your cosmetic procedures. If you are interested in information for this 6-month, 0% interest program, simply ask a representative of our staff or see the link on the Patient Information tab of our website to enroll at www. laserdermdoc.com.

Medical Records:

We will gladly reproduce your medical records for another doctor's office with a signed "Release of Medical Records" form indicating the office to which those records should be sent. There is an evaluation and reproduction fee of $25.00 for files with less than 10 appointments and a $50.00 fee for files with greater than 10 appointments. This fee must be paid in advance of the reproduction. Alternatively, a medical record copy service can be contracted at your expense to come to the office to duplicate them onsite.

Email addresses and Cell phone numbers:

We require both an email address and mobile contact numbers for every patient. This contact information will only be used for appointment reminders or under emergent circumstances when we need to contact you. Additionally, future billing statements may be delivered to your e-mail address.

Failure to show:

If you are scheduled for an appointment and fail to appear for your appointment, there will be a $25.00 fee assessed to your account for medical appointments or a $50.00 fee assessed if for cosmetic appointments, medical procedures or surgeries. Notification to our offices of a conflict in your schedule 48 hours in advance, or through our Appointment Reminder System, will keep these "failure to show" fees from being assessed.

_____

SIGNATURE DATE SIGNED

_____

PRINT YOUR NAME

COSMETIC DERMATOLOGY of ORANGE COUNTY

REQUIRED PATIENT INFORMATION (Please print) Today's Date ___/___/___

Name _____
Last First Middle

Mailing Address: _____
Street City State ZIP

Mobile Phone: (_____) _____ Home Phone: (_____) _____ SS#: ____-___-_____

Work Phone: (_____) _____ E-mail Address: _____

Date of Birth: ___/___/___ Sex: _____ Marital Status _____

GOVERNMENT REQUIRED Demographics:

Race: ☐ Other/Non-disclosed ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Ethnicity: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White
☐ Unreported/Non-disclosed

Language: ☐ English ☐ Spanish ☐ Other: _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First Middle

Mailing Address: _____
Street City State ZIP

Mobile Phone: (_____) _____ Work Phone: (_____) _____ SS#: ____-___-_____

Source: ☐ Doctor Referral: _____ ☐ Insurance Referral ☐ Friend
☐ Internet: _____ ☐ Advertisement ☐ Other: _____

INSURANCE INFORMATION (Please present insurance card and State ID at time of check-in)

Primary Insurance Name: _____
Insurance Address: _____
Name of Primary Insured: _____
Insured Member ID#: _____ Insured Date of Birth: ___/___/___
Group ID#: _____
Employer Name: _____
Employer Address: _____
Employer Phone #: (____) _____
Relationship of patient to Insured: _____
Other family members that are patients: _____
Pharmacy of choice: _____ Phone #: (____) _____
In case of Emergency, who should be notified? _____ Phone #: (____) _____
Primary Care Physician: _____

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 or Responsible Party Signature: _____ Date: ___/___/____

__ Copy of insurance card attached (both sides) Updated by: _____

COSMETIC DERMATOLOGY of ORANGE COUNTY

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. Coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services, co-insurances and co-payments for those patients, applicable co-payments and deductibles will be collected at time of service. There will be a $25.00 billing fee added to your account if payment is not collected at time of service. This fee will however be waived if payment is received within the office within forty-eight (48) hours. We accept payment in the form of cash, check, debit or credit card (VISA, MasterCard, American Express or Discover). In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature: _____ Date: ____/____/_____

PLEASE CHECK IF YOU HAVE EVER HAD:

____ Asthma
____ Skin Cancer
____ Lung Disease
____ Diabetes
____ Measles
____ Boils
____ Herpes (Shingles or Cold Sores)
____ Venereal Disease
____ Recurrent Skin Infections
____ Hay Fever
____ Heart Disease
____ Eye Disease
____ Blood Disorders
____ Mumps
____ Hepatitis
____ Internal Cancer
____ High Blood Pressure
____ Neurological Disease (e.g. Epilepsy)
____ Inherited Diseases
____ Chicken Pox
____ Colitis/Bowel Problems
____ Keloids/Thick Scars
____ Dry Flaking/Cracking Skin
____ Autoimmune Disorders (Lupus, Scleroderma, Fibromyalgia, other: _____)
____ Other Skin Conditions, specify: _____

PLEASE CHECK IF YOU:

____ Bruise easily
____ Suffer from heartburn or indigestion
____ Have abnormal or rapid pulse/heartbeat
____ Suffer from fainting
____ Suffer from recurring diarrhea
____ Suffer from headaches
____ Use a pack-maker heart device
____ Wear contact lenses

Other information which you would like to bring to the Doctor's attention requiring your medical condition, medical history or your family's medical history: _____

_____

_____

_____

How did you learn of Cosmetic Dermatology of Orange County:

☐ Medical Provider
Provider name: _____

☐ Insurance Carrier
Carrier name: _____

☐ Friend or Family Member
Name: _____

☐ Internet
Site : _____

☐ Cosmetic Dermatology of Orange County Site
Search Engine : _____

☐ Social Media Site: _____

☐ Other: _____

Medical and Financial Information Authorization Release

Generally, the Health Information Portability and Accountability Act (HIPAA) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as specific phone numbers. We will take all reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. Use and disclosure may be permitted without prior consent in circumstances of emergency.

I authorize the staff of Cosmetic Dermatology of Orange County to release:

☐ Financial Info and/or ☐ Medical Info or ☐ NO Information _____
Initials

Detailed messages of the above indicated information can be left via/with ***(check all that apply)***:

☐ Mobile Phone ☐ Home Phone ☐ Work Phone ☐ E-mail Address

☐ Spouse/Partner - Phone: _____

☐ Parent/Guardian - Phone: _____

☐ Other: _____ - Phone: _____

CONSENT FOR EXAMINATION AND TREATMENT

I hereby authorize Cheryl L. Effron, M.D. to examine the patient named on the Patient Information form and to administer any treatment the doctor deems necessary for the patient. I agree to pay in full for all services at the time of the office visit, unless other arrangements have been agreed to in advance by the Doctor.

_____ ____/____/_____

Signature of Patient or Patient's Guardian/Parent Date

COSMETIC DERMATOLOGY of ORANGE COUNTY
Dermatology Medical History

Name _____ Date of Birth: ___/___/___ Today's Date ___/___/___
Last First Middle

Reason for today's visit: _____

Are you allergic to any medications or injectable anesthesia? ☐ Yes ☐ No If Yes, please list below:

1. _____ 2. _____
3. _____ 4. _____

List all medications you are currently taking (including prescription, over-the-counter meds, vitamins and herbal supplements):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (please check all that apply)

LUNGS:

Bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Morning Cough	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No

CARDIOVASCULAR:

High Blood Pressure	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Phlebitis	☐ Yes	☐ No
Inflammation of the veins	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No
Pace-maker	☐ Yes	☐ No

OTHER SYSTEMIC:

Diabetes	☐ Yes	☐ No
Excessive thirst/hunger	☐ Yes	☐ No
Amputation	☐ Yes	☐ No
Thyroid	☐ Yes	☐ No
Kidney	☐ Yes	☐ No
Dialysis	☐ Yes	☐ No
Bladder	☐ Yes	☐ No
Frequency/burning	☐ Yes	☐ No
Gastrointestinal	☐ Yes	☐ No
Stomach absorptive disorder	☐ Yes	☐ No
Nausea, vomiting, diarrhea	☐ Yes	☐ No
when taking antibiotics	☐ Yes	☐ No
Yeast infections while taking	☐ Yes	☐ No
Antibiotics	☐ Yes	☐ No
Arthritis/Joint Deformity	☐ Yes	☐ No
Arthralgia	☐ Yes	☐ No
Limited Motion	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Convulsions, Epilepsy, Seizures	☐ Yes	☐ No
or Fainting	☐ Yes	☐ No

List any other diseases or conditions: _____

List surgical procedures you have had in the past 6 months: _____

SKIN:

Have you had skin cancer?	☐ Yes	☐ No – If Yes,	_____
Has anyone in your family had skin cancer?	☐ Yes	☐ No – If Yes,	_____
Do you have a history of any specific skin disease?	☐ Yes	☐ No – If Yes,	_____
Do you have problems with healing?	☐ Yes	☐ No	
Do you develop keloids (scars) after surgery?	☐ Yes	☐ No	
Do you bleed easily?	☐ Yes	☐ No	

Do you develop skin rashes in reaction to: ☐ Medication ☐ Food ☐ Environment ☐ Bandages
☐ Topical Neosporin ☐ Other: _____

SOCIAL HISTORY:

Do you drink alcohol? ☐ Yes ☐ No If Yes, _____ drinks per day
Do you use IV drugs? ☐ Yes ☐ No If Yes, what? _____ How often? _____
Do you smoke? ☐ Yes ☐ No If yes, how much? _____
Have you had or have you been exposed to HIV (AIDS)? ☐ Yes ☐ No
WOMEN – Are you pregnant? ☐ Yes ☐ No Due Date ____/____/____
What is your occupation? _____ Hobbies? _____ Sports? _____

Completed by: ☐ Patient – Patient Signature: _____ Date: _____
☐ Medical Asst: _____(initials)

COSMETIC DERMATOLOGY of ORANGE COUNTY

Cosmetic Interest Evaluation

Name _____
Last First Middle

Other than the services that we already provide for you, what other services would you like to learn about? Check all that apply:

- ☐ Laser Tattoo Removal or Modification
- ☐ Acne Treatments:
  - ☐ Chemical Peels
  - ☐ Laser Breakout Reduction
  - ☐ Product Routines
  - ☐ Scar Reduction
  - ☐ Pigment Removal from Trauma
- ☐ Laser Skin Rejuvenation & Anti-aging:
  - ☐ Fraxelated CO2 for Resurfacing/Texture
  - ☐ Tightening
  - ☐ Fine Line Reduction
  - ☐ Red/Brown Spot Reduction
  - ☐ Redness/Blotchy coloration
  - ☐ Surfaced Blood Vessels/Broken Capillaries
  - ☐ Brown/Red spots on face, neck or chest
  - ☐ Brown/Red spots on hands/forearms
  - ☐ Scar Tissue/Stretch Mark Reduction
  - ☐ Pore Size Reduction
  - ☐ Birthmark Revision
  - ☐ Ingrown Hair Treatments
- ☐ Laser Cellulite Smoothing and Reduction
- ☐ Laser Nail Fungus Treatment
- ☐ Eye Lash Enhancement
- ☐ Laser Hair Removal - area: _____
- ☐ Scar Tissue Reduction
- ☐ Volume Replacement
  - ☐ Cheeks
  - ☐ Hands
- ☐ Fillers for Line Reduction
  - ☐ Vertical Lip Lines
  - ☐ Smile Lines
  - ☐ Lip definition enhancement
- ☐ Neuro-relaxers for Lines/Wrinkle Reduction
  - ☐ Crows-feet (eyes)
  - ☐ Frown Lines
  - ☐ Forehead lines
  - ☐ Excessive Sweat Reduction
- ☐ Leg Vein Reduction
- ☐ Aesthetic Services
  - ☐ Peels (Acne, Tone, Texture, Complexion)
  - ☐ DermaSweep (Non-abrasive MicroDerm)
  - ☐ Facials
  - ☐ Skin Care Consultation
  - ☐ Skin Product Consult/Custom Routine

Other concerns not listed above for which you would like information:

_____

_____

_____

☐ - I approve use of my e-mail address for transmission of specials, product offerings and new service announcements

E-mail Address: _____

COSMETIC DERMATOLOGY of ORANGE COUNTY

Insurance Company Billing Policy

Dear Valued Patient:

As a convenience to our patients, we are contracted with certain insurance carriers to bill for the services rendered for a given date of service. If we are not contracted with a carrier, we expect payment in full at time of services rendered.

It is our policy to bill an insurance company on your behalf up to two times. If the insurance company fails to honor their agreement to pay timely after two submissions, the balance will become the patient's obligation. If your insurance company fails to pay your claim you will be notified in writing. If you receive a notice, please feel free to contact your insurance company. We will gladly accept their payment on your behalf. However, please note that from the date you receive your statement, payment in full is required and the balance can be refunded to you if payment is received from your carrier in the future.

Thank you for your loyalty and patronage.

I certify that I have read and understand the above insurance company billing policy.

_____
Patient Name

_____
Patient Signature

_____
Signature Date

Blanket Assignment Form

I request that payment under my medical insurance program be made to Cheryl L. Effron, M.D., Inc. for any and all services rendered to me by this provider.

_____
Patient Name

_____
Patient Signature

_____
Signature Date