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) Huntington Beach (click for directions)
500 S. Anaheim Hills Rd #210 17822 Beach Blvd #452
Anaheim, CA 92807 Huntington Beach, CA 92647
714-974-3272 714-848-5851
714-974-4517 - fax 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 intention.

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

PLEASE CHECK IF YOU:

___ Bruise easily  ___ Suffer from recurring diarrhea
___ Suffer from heartburn or indigestion  ___ Suffer from headaches
___ Have an abnormal or rapid pulse/heartbeat  ___ Use a pack-maker heart device
___ Suffer from fainting  ___ 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: _______________________________
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

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
### 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  
- Arthritis/Joint Deformity  □ Yes  □ No  
- Arthralgia  □ Yes  □ No  
- Limited Motion  □ Yes  □ No  
- Artificial Joints  □ Yes  □ No  
- Convulsions, Epilepsy, Seizures  □ Yes  □ No  
- Frequency/burning  □ Yes  □ No  
- Gastrointestinal  □ 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 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
☐ Laser Hair Removal - area: _______________

☐ Acne Treatments:
☐ Chemical Peels
☐ Laser Breakout Reduction
☐ Product Routines
☐ Scar Reduction
☐ Pigment Removal from Trauma

☐ Scar Tissue Reduction
☐ Volume Replacement
☐ Cheeks
☐ Hands

☐ Scar Reduction

☐ Laser Skin Rejuvenation & Anti-aging:
☐ Fraxelated CO2 for Resurfacing/Texture
☐ 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

☐ 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:  _____________________________________________
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