Name:______________________________

Date:_______________________________

Email Address: ________________________

HOW DID YOU HEAR ABOUT US?

Please circle one of the following:

1) Friend. Who?

2) Internet

3) Verizon Yellow Pages

4) AT&T

5) Yellow Book

6) Walk-In / Drive By

7) Doctor Referral. Who?

8) Other_____________________________

PATIENT INFORMATION

(Please Print)

Today's Date ___/___/___

Name ____
Last *First* *M.I.*

Mailing Address ____
City *State* *Zip*

Home Phone (   ) __________ Work Phone (   ) __________ Cell Phone (   ) __________ SS# __________

Date of Birth ___/___/___ Age ________ Sex ________ Marital Status __________

PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name ____
Last *First* *M.I.*

EMAIL ADDRESS ______________________

Mailing Address ____
City *State* *Zip*

Home Phone __________ Work Phone __________ SS# __________
Area Code *Area Code*

Date of Birth ___/___/___ Sex ________

INSURANCE INFORMATION *(Please present insurance card at time of check in.)*

Primary Insurance Name ______________________

Ins. Address ______________________

Name of Insured ______________________

Insured's ID # ______________________

Group # ______________________

Employer Name ______________________

Employer Address ______________________

Employer Phone ______________________
Area Code

Relationship of patient to the Insured ______________________

Secondary Insurance Name ______________________

Ins. Address ______________________

Name of Insured ______________________

Insured's ID # ______________________

Group # ______________________

Employer Name ______________________

Employer Address ______________________

Employer Phone ______________________
Area Code

Relationship of patient to the Insured ______________________

In case of Emergency, who should be notified? ______________________ Phone __________

Referred by: ____

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 ___/___/___

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 policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. The laser portion of this practice is under the direction of our laser supervising physician who is a nonprovider for certain insurance companies. You will be responsible for all copays and any other balance due from your insurance company. We accept payment in the form of cash, check, or credit card. In the even of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a $10.00 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 ___/___/___

☐ **Copy of insurance card (both sides) attached.**

☐ Updated By: ______________________

AK-NPP

MEDICAL HISTORY FORM

Name____ Date of Birth__________ Date_______

WHAT IS THE REASON FOR YOUR VISIT TODAY?____

____

____

ALLERGIES:____

____

DERMATOLOGIC HISTORY: Do you have a history of:

1. □ Melanoma
2. □ Squamous Cell Carcinoma
3. □ Basal Cell Carcinoma
4. □ Skin Cancer, Uncertain Type
5. □ Dysplastic (Atypical) Moles
6. □ Actinic Keratosis (Pre-cancer)
7. □ Eczema
8. □ Psoriasis

Other______________________________

FAMILY HISTORY: Do family members have a history of any of the following?

1. □ Melanoma (if yes who__________________)
2. □ Squamous Cell Carcinoma
3. □ Basal Cell Carcinoma
4. □ Skin Cancer, Uncertain Type
5. □ Dysplastic (Atypical) Moles)
6. □ Eczema/Psoriasis

Other______________________________

SURGICAL HISTORY

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________
6. ____________________________
7. ____________________________

MEDICAL HISTORY: Please list your current/prior medical problems:

____
____
____
____
____
____
____

MEDICATIONS : please list current medications

Skin Medications

1. ____________________________
2. ____________________________
3. ____________________________

Other medications

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________
6. ____________________________
7. ____________________________
8. ____________________________

□ SEE LIST

SOCIAL HISTORY

1. Alcohol: Y / N   2. Smoking: Y / N

3. Lifetime sun exposure: Light Medium Heavy

4. Current sun exposure: Light Medium Heavy

RACE: (circle one) American Indian or Alaskan Native Asian African American

Caucasian Hispanic Native Hawaiian or Pacific Islander Other Decline

LANGUAGE:

English Spanish Other: ______________________________

Daniel Taheri, M.D., Inc.
Daniel Taheri, M.D., PC.

Payment Policy:

1. We do not accept checks for any amount exceeding $40.00.

2. Cosmetic Procedures must be paid for in cash or by credit card before services are rendered.

3. No refunds will be issued all sales are final.

Cancellation Policy:

A $35.00 cancellation fee will apply to appoinbnents not cancelled within 48 hours. This fee pertains to all laser and acne surgery appointments.

Patient Name: ______________________________

Patient/Parent/Guardian Signature: ______________________________

Date: ____________________

Daniel P. Taheri M.D.
La Laser Center PC

TO ALL PATIENTS WITH INSURANCE COVERAGE

PLEASE READ AND SIGN

If you have insurance coverage it is your responsibility to know the policy and guidelines of that company. What that means is, you are responsible to know your deductible, co-pay, type of coverage and whether or not you need an authorization to be seen at our office. If we are not your primary care physician, most companies require you to be authorized before seeing any other doctor. This is why it is important that you notify us before doing so.

With, so many ~policies around it is virtually impossible for this office to know the details of every insurance policy We will try and help you as much as possible, but should your insurance deny your bill you will be held liable for any charges/outstanding balance.

IMPORTANT! If you have an HMO, EPQ, and/or Managed Care plan you must have an authorization to be seen. If we don't have an authorization, you will not be seen by the doctor.

If we can answer any questions, or assist you in any way, will be happy to.

Thank you.

____

Patient Name

______________________________________ ________________

Patient or Responsible Party's Signature Date

Daniel Taheri M.D., Inc.

Dermatology Photo Consent Agreement

Photo Consent Agreement:

The undersigned does hereby authorize

Daniel Taheri M.D., Inc – La Laser Center

____

Name (Please Print)

The undersigned authorize Dr. Daniel Taheri M.D., Inc to permit the use of photographs showing medical before and after laser and cosmetic treatment(s) being done.

The undersigned agrees that Dr. Daniel Taheri M.D., Inc may use name, likeness and biographical information supplied by the undersigned.

The undersigned releases and forever discharges Dr. Daniel Taheri M.D., Inc, its agents, officers and employees from any and all claims and demands arising out or in connection with use of said photographs/images, including but not limited to, any claims for invasion of privacy or defamation.

Accepted and Agreed:

____

Signature of Subject

____

Signature of Witness

____

Date:

Dermatology and Laser Center

HIPPA ACKNOWLEDGEMENT FORM

I understand that as my condition to my receiving treatment from Dr. Taheri, the office of Dr. Taheri may use or disclose my personally identified health information for treatment, to obtain payment for the treatment provided, and as necessary for the operations of Dr. Taheri's office. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to rite and which I have had the opportunity to review.

I understand that the privacy practices described in the Privacy Notice may change over time, and that I have a right to obtain any revised Privacy Notice by contacting the office of Dr. Taheri to make such request.

I also understand that I have a right to request Dr. Taheri to restrict how my health information is used or disclosed. Dr. Taheri does not have to agree to my request for the restrictions, but if he does agree, he is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that Dr. Taheri has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

Name: ____

Date: ____

Signature: ____

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1 – It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2 – I understand and agree that this arbitration agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, the, in addition to myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the CMA/CMA Medical Arbitration Rules.

ARTICLE 3 – I agree that the arbitrators have the same immunity from civil liability as that of judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4 – I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

ARTICLE 5 - On behalf of myself and all others bound by this agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Healthcare Association (CHA) and the California Medical Association (CMA), as they may be amended from time to time, which are hereby incorporated into this agreement. A copy of these Rules is included in the pamphlet in which this agreement is found. Additional copies of the Rules are available from the California Medical Association, P.O. Box 7690, San Francisco, Ca. 94120-7690, Attention: Arbitration Rules. I understand that disputes covered by this agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 6 – OPTIONAL: RETROACTIVE EFFECT
If I intend this agreement to cover services rendered before the date it is signed (for example: emergency treatment), I have indicated the earlier date I intended this agreement to be effective from and initialed below.

Earlier effective date: _______________ Patient's Initials: ____________

ARTICLE 7 – I have read and understood all the information in the pamphlet, including the explanation of the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision:

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

____ Dated: ________________, 20 _____
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)
If signed by other than patient, indicate relationship: ______________________________

PHYSICIAN'S AGREEMENT TO ARBITRATE
In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this agreement and in the rules specified in Article 4 above.

____ Dated: ________________, 20 _____
(Physician or Duly-Authorized Representative)

____________________ ____
Title-e.g., Partner, President, etc. Print name of Physician, Medical Group, Partnership or Association

California Medical Association, 2001

Dr. Daniel P. Taheri M.D.
LA LASER CENTER PC

Contract Language

I ______________________________, agree not to denigrate, defame, disparage or cast aspersions upon Dr. Daniel Taheri and / or LA Laser Surgery & Westwood Dermatology and / or any of their products or services on any internet website and / or internet forum or medium of any kind. Furthermore, you agree to make every effort to prevent your friends or family members from doing the same. You acknowledge the receipt of good and valuable consideration for this agreement by your acceptance of medical services from Dr. Daniel Taheri and / or LA Laser Surgery & Westwood Dermatology.

______________________________ ______________

Patient or Legal Guardian Name Date

____

Patient or Legal Guardian Signature

Dermatology and Laser Center

I, ____________________________________, have been informed by my physician that I will be
Last name First name
responsible for services provided that are deemed medically unnecessary by insurance company.

Agreement

I understand and agree that I will be personally and fully responsibly for full payment for the services rendered if my insurance company denies payment.

____ _______________

Patient Signature Date

____ _______________

Witness Signature Date

PHYSICIAN-PATIENT AGREEMENT

A. **We Care About Our Patients:**

Physician and staff have spent years acquiring the skill and expertise needed to do all that is possible under our state of the art dermatological procedures to heal patients skin problems, help their skin return to its healthy, youthful appearance and vitality, and to help restore the confidence one has when your skin looks great.

It is of paramount importance to Physician and staff that our patients understand that we care about the service you receive at La Laser Center facilities. Accordingly, we honor and respect your feedback. If you do something right please let us know. Also, if we somehow disappoint you inj the service we provide, please ask staff at the front counter for the name of our supervisor in charge of patient satisfaction and, we will arrange for you to communicate with your concerns either in person or via email. If we feel your comment has merit we will notify you of what measures we are taking to improve service.

B. **Patient Agres to Inform Office If Patient is Not Satisfied With Our Services**

Like all other dermatological offices, in spite of the best efforts by our staff to provide optimal care, occasions will arise when a patient will leave upset without communicating to staff what caused the upset. When this happens, we are left without the information we need to evaluate our services. Therefore, by signing below, Patient agrees to communicate to staff regarding any problems arising from our service which caused Patient to be less than satisfied with our treatment.

C. **Physician Agrees Not to Provide Patient's Personal or Medical Information to Marketers:**

Physicians are forbidden by law from receiving money for selling lists of patient's names, addresses and phone numbers or medical information to companies that sell products or services directly to patients without patient authorization. Unfortunately, some medical offices find loopholes attempting to lawfully circumvent these restrictions. If this occurs the patient can be targeted with unwanted advances from marketers. Physician believes this is improper and most often not in the best interest of patient's. Therefore, Physician agrees not to release Patient's personal or medical information to anyone outside this office, other than patient without Patient's consent, unless Physician is commanded to release such information under court order or by order of an administrative agency or unless Physician is served with a valid power of attorney for medical purposed for Patient.

C. **Posting of Comments by Patients About Physician, His Staff and Treatment of Web Sites:**

Physician has invested significant advertising, marketing and financial expenditures in developing his practice. Because we live in an age where any person from grade school upward can daily go onto the internet and post comments about anything for any reason, any doctor can easily be damaged by misguided, misinformed, and sometimes disingenuous comments posted anonymously on the internet. In fact almost no doctors receive 100% positive reviews from all their patients.

Without medical training and experience, Patients are not qualified to provide opinions on whether the dermatological treatment selected was appropriate. Some dermatological conditions do not respond well to treatment. It is sometimes therefore not possible to please all patients. Therefore, a growing number of dermatologists are finding themselves unfairly criticized on internet postings without having a meaningful chance to correct such misinformation. Therefore to address this growing problem, Physician is requiring all patients in its practice to sign this mutual agreement. Nothing in this agreement prevents a patient from posting comments about the physician on web pages. However in consideration for Physician's treatment and protection of Patient confidential information from marketers as has been detailed above, Patient hereby agrees:

a. If the undersigned Patient prepares comments for posting on any website or web page relating to Physician's treatment of the patient, the patient hereby exclusively assigns, for a period of five years form Physician's last date of treatment, all his/her intellectual property rights to such comments, including copyrights, to Physician for any written, pictorial or electronic commentary. This assignment shall be operative and effective at the time of the creation of each Patient comment;

b. Patient agrees that he/she will not post any comments about his Physician, staff or the dermatological treatments Patient received, anonymously. Further Patient agrees to attach his/her first, last name and middle initial to any such post of comments on the internet.

Patient and Physician acknowledge that breach of this agreement may result in serious and irreparable harm. Patient and Physician agree that legal and equitable remedies may be utilized, including a resort to injunctive relieve to remedy any breach of this agreement. Should a breach of this agreement result in litigation, the prevailing party to such litigation shall be entitled to an award for what party's reasonable costs, expense s, and attorney's fees incurred in the litigation.

Patient has been provided an opportunity to ask questions about this mutual agreement. Patient hereby agrees to the terms and conditions of this mutual agreement with Physician.

SO AGREED THIS ____ day of __________, _____________,

____

Patient's Signature

____

Print Patient's Name

____

Physicians Signature