FRESNO & VISALIA
DERMATOLOGY SPECIALISTS

Welcome
Carlos Paz, MD, PhD
Betsy McCarley Billys, MD
Rhonda Bonilla, FNP
Melissa Manriques, FNP
& Allison Smith, PA

Dear Patient,

We are delighted to welcome you to Fresno and Visalia Dermatology Specialists, the offices of Dr. Carlos Paz. This letter contains answers to some of the most commonly asked questions by patients entering our offices.

Fresno Dermatology Specialists is located in the Meridian Professional Center on the Northwest corner of Chestnut and Herndon Avenues. Our office in Visalia is located on Akers Street and Hillsdale Avenue. We are a full service dermatology practice providing medical, cosmetic, and surgical services to patients of all ages. Our hours are Monday through Friday from 8:00 am to 5:00 pm.

All new patients are asked to complete the Patient Registration, Financial Policy, Notice of Privacy Practices and Health History in full and provide them to the receptionist when checking in for your initial appointment. If you are unable to keep your appointment, please give at least 24 hours notice otherwise we charge a late cancellation/missed appointment fee.

For the benefit of our patients, we are contracted with several insurance carriers. You will want to check with your insurance company to find out if we are listed as providers within your particular network. As part of our contract with your insurance carrier, we are required to collect any co-pay(s) from you at the time of service. We also collect any unmet deductible and non-covered services at the time of service. Please come prepared with your co-pay, identification card, and insurance card.

If you have any questions or concerns, please call our office at 559-233-3376. We look forward to meeting you soon!

Sincerely,

Fresno & Visalia Dermatology Specialists

7025 N. Chestnut Ave Suite 105 | Fresno, CA 93720
TEL. 559.233.3376 | FAX. 559.233.6647

128 N. Akers St, Suite C | Visalia, CA 93291
TEL. 559.385.2133 | FAX. 559.385.2134

www.pazderm.com

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Patient Registration

Carlos Paz, MD, PhD
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Name (Last, First, MI): ☐ Jr. ☐ Sr

Date of Birth: / / Sex: ☐ M ☐ F ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Address: Apt.#

City: State: Zip Code:

Email Address: Can we e-mail you appointment reminders? ☐ Yes ☐ No

Cell Phone: Can we text you appointment reminders? ☐ Yes ☐ No

Home Phone:

Patient's Social Security #:

Employee Name: Address:

Primary Insurance – Insurance Company Name:

Subscriber Name: Subscriber's Date of Birth: / / (required)

Subscriber's Social Security #:

Subscriber ID: Group #: Policy #

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance (If applicable) – Insurance Company Name:

Subscriber Name: Subscriber's Date of Birth: / / (required)

Subscriber's Social Security #:

Subscriber ID: Group #: Policy #

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Emergency Contact:

Name Relationship to patient Phone Number

Please identify and provide phone number for any individual(s) with whom our staff can discuss your medical condition or bills.

1. ☐ Medical Information ☐ Billing information

2. ☐ Medical Information ☐ Billing information

TREATMENT CONSENT, I hereby give consent for medical treatment to the providers with Fresno & Visalia Dermatology Specialists to care for myself *or* I am duly authorized by the patient as his/her agent or guardian to give consent for such treatment.

Patient Signature (Or signature by parent or guardian if patient is a minor) Date

FRESNO & VISALIA
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Dermatology Medical History

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Name (Last, First, MI): ☐ Jr. ☐ Sr

Name of Primary Care Physician (PCP) and address:

How did you hear about our office? ☐ Dr. ☐ Insurance Plan ☐ Google ☐ Yelp

☐ Family/Friend ☐ Newspaper ☐ Magazine ☐ Radio ☐ Other (please specify)

Pharmacy Name: Pharmacy Phone:

Pharmacy Address (or cross streets):

Reason for today's visit (chief complaint)?

How long have you had this problem? What parts of your body are affected?

How does this problem bother you? (symptoms):

What treatments have you received for this problem?

Is your problem: ☐ Worsening? ☐ Stable? ☐ Improving?

Cosmetic Consultation: Our office offers a variety of cosmetic services including Botox, fillers, laser treatments, liposuction and cosmetic surgery. Are you interested in learning more about these services during your office visit? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Do you plan to become pregnant soon? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Alerts: (Check all that apply)

☐ Allergy to lidocaine
☐ Artificial topical antibiotic ointments
☐ Premedication prior to procedures
☐ Artificial joints (past 2 years)
☐ Allergy to heart valve
☐ Blood thinners
☐ Pacemaker
☐ MRSA
☐ None

Any allergy to any other medication not listed above? ☐ Yes ☐ No If yes, please list below:

Past Medical History: (Check all that apply)

☐ Anxiety
☐ Arthritis
☐ Artificial joints
☐ Asthma
☐ Atrial fibrillation
☐ Bone Marrow Transplantation
☐ BPH (Benign Prostatic Hyperplasia)
☐ Breast Cancer
☐ Colon Cancer
☐ COPD (Emphysema)
☐ Coronary Artery Disease
☐ Depression
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD (Acid reflux)
☐ Hearing Loss
☐ Hepatitis
☐ HIV/AIDS
☐ Hypercholesterolemia
☐ Hypertension
☐ Hyperthyroidism
☐ Hyperthyroidism
☐ Leukemia
☐ Lung Cancer
☐ Lymphoma
☐ Pacemaker
☐ Prostate Cancer
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ Valve Replacement
☐ None
☐ Other ________________________________

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List all medications you are currently taking (including prescriptions, over-the-counter meds, etc.)

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

Past Surgical History: (Check all that apply)

☐ Appendix Removed
☐ Basal Cell Carcinoma Surgery
☐ Biological Valve Replacement
☐ Bladder Removed
☐ Breast Biopsy (Right, Left, Bilateral)
☐ Breast Implants
☐ Breast Reduction
☐ Colectomy: Colon Cancer Resection
☐ Colectomy: Diverticulitis
☐ Colectomy: IBD
☐ Coronary Artery Bypass
☐ Gallbladder Removed
☐ Heart Transplant
☐ Hysterectomy: Fibroids
☐ Hysterectomy: Uterine Cancer
☐ Joint Replacement, Hip (Right, Left, Bilateral)
☐ Joint Replacement, Knee (Right, Left, Bilateral)
☐ Joint Replacement within last 2 years
☐ Kidney Biopsy
☐ Kidney Removed (Right, Left)
☐ Kidney Stone Removal
☐ Kidney Transplant
☐ Lumpectomy (Right, Left, Bilateral)
☐ Mastectomy (Right, Left, Bilateral)
☐ Mechanical Valve Replacement
☐ Melanoma Surgery
☐ Ovaries Removed: Cyst
☐ Melanoma Surgery
☐ Ovaries Removed: Cyst
☐ Ovaries Removed: Endometriosis
☐ Ovaries Removed: Ovarian Cancer
☐ Prostate Biopsy
☐ Prostate Removed: Prostate Cancer
☐ PTCA
☐ Skin Biopsy
☐ Spleen Removed
☐ Squamous Cell Carcinoma Surgery
☐ Testicles Removed (Right, Left, Bilateral)
☐ None
☐ Other ____

Skin Disease History: (Check all that apply)

☐ Abnormal Moles
☐ Actinic Keratoses
☐ Acne
☐ Basal Cell Skin Carcinoma
☐ Blistering Sunburns
☐ Dry Skin
☐ Eczema
☐ Flaking or Itchy Scalp
☐ Hay Fever/Allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous Moles
☐ Psoriasis
☐ Squamous Cell Skin Carcinoma
☐ None
☐ Other____

Do you wear sunscreen? ☐ YES ☐ NO If yes, what SPF? ____ Do you tan in tanning salon? ☐ YES ☐ NO

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Do you have a family history of Melanoma? ☐ YES ☐ NO If yes, which relative(s) ____________________

Any other skin cancer family history? ____________________

Mark square next to any symptom or condition you are having:

General
- ☐ fever
- ☐ chills
- ☐ weight loss
- ☐ fatigue

Head, Eyes, Ears, Nose, Throat
- ☐ visual problems
- ☐ dry eyes
- ☐ eye disease
- ☐ ringing in ears
- ☐ ear disease
- ☐ bloody nose
- ☐ stuffy nose
- ☐ swallowing difficulties
- ☐ dry mouth
- ☐ sore mouth
- ☐ mouth ulcers

Cardiovascular
- ☐ pacemaker
- ☐ heart disease
- ☐ mitral valve prolapse
- ☐ hypertension
- ☐ chest pain

Respiratory
- ☐ cough
- ☐ difficulty breathing
- ☐ lung disease
- ☐ tuberculosis
- ☐ coughing up blood

Gastrointestinal
- ☐ liver disease
- ☐ intestinal disease
- ☐ heartburn/indigestion
- ☐ abdominal/stomach pain
- ☐ diarrhea
- ☐ constipation
- ☐ blood in stools or black stool
- ☐ rectal pain
- ☐ nausea
- ☐ vomiting

Genitourinary
- ☐ kidney disease
- ☐ bladder disease
- ☐ blood in urine/dark urine
- ☐ female problems
- ☐ stillbirth/spontaneous abortion
- ☐ problems with urination

Musculoskeletal
- ☐ joint aches
- ☐ swollen joints
- ☐ muscle aches
- ☐ muscle weakness
- ☐ back pain
- ☐ ankle swelling
- ☐ fingers sensitive to cold

Neurologic
- ☐ epilepsy/seizures
- ☐ headaches
- ☐ stroke
- ☐ dizziness
- ☐ disorientation
- ☐ confusion
- ☐ memory loss
- ☐ numbness
- ☐ double vision
- ☐ loss of consciousness

Psychiatric
- ☐ nervous breakdown
- ☐ depression
- ☐ insomnia

Endocrine
- ☐ diabetes
- ☐ enlarged glands
- ☐ hormonal problems
- ☐ thyroid disease

Hematologic/Lymphatic
- ☐ anemia
- ☐ free bleeding tendency

Immunologic
- ☐ immune deficiency
- ☐ frequent infections

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Social History: (Check all that apply)

Cigarette Smoking
☐ Never smoked
☐ Quit: former smoker
☐ Smokes less than daily
☐ Smokes daily

Do you drink alcohol?
☐ Yes
☐ No

How often do you exercise?
☐ Once a day
☐ A few times a week
☐ Occasionally
☐ Never

What is your caffeine use? ☐ Once a day ☐ A few times a week ☐ A few times a month ☐ Never

Language:
☐ English
☐ Spanish
☐ Other: ______________________

Ethnicity:
☐ Hispanic/Latino
☐ Non-Hispanic/Latino

Race:
☐ White
☐ Black/African American
☐ American or Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Asian

If needed, please elaborate on any of the above:

Patient Signature (Or signature by parent or guardian if patient is a minor) Date

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Financial and Billing Policies

Carlos Paz, MD, PhD
Betsy McCarley Billys, MD
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Thank you for choosing Fresno and Visalia Dermatology Specialists. We are committed to providing excellent skin health care in a patient-focused environment. We are contracted with several insurance plans and will directly bill your insurance under these plans.

We understand that billing and payment for health care services can be confusing and complicated. It is important for you to know the information contained in your specific health plan, including any co-payments, deductibles, exclusions, and other provisions. If you have any questions, we encourage you to call your health plan's member services department. Their number should be listed on the back of your insurance card.

Because we will submit claims to your insurance company, we ask that you inform us if your personal or insurance information changes. The lack of current information may cause delays in care and make you personally responsible for the cost of the entire visit.

Insurance Clause:
If your office visit precedes the effective date of your insurance coverage or is not covered by your insurance, you will be held responsible for all fees incurred as a result of your visit. It is the patient's responsibility to confirm that we are in network with their plan and that specific procedures are covered under their particular policy.

Co-payments, Deductibles, and Co-Insurance:
Co-payments and any unmet deductibles are due at the time of your office visit. There will be a $10.00 fee charged if co-payments are not paid at the time of service. Under the terms of our contract with the insurance plans, we cannot waive any co-payments, deductibles, or co-insurance amounts defined as patient responsibility. If you have any questions regarding your co-payments or deductibles, please call your insurance company. For your convenience, we accept cash, checks, all major credit cards, and Care Credit.

Deposits:
For certain procedures not covered by insurance, you may be required to pay a deposit or pay for the service in full, prior to treatment.

Prior Authorization:
Most health plans require authorization for elective services. If your insurance company decides your service was not medically necessary, or is not a covered service, you will be asked to pay the balance that insurance did not cover.

We are not contracted with Medi-Cal, or any Medi-Cal managed care plan, and therefore cannot treat any patient with these insurance profiles.

Patient Responsibility Balances:
All patient responsible balances must be paid in full upon receipt of your statement. You should have already received an explanation of benefits from your insurance carrier. By this time, at least 30 days have passed since your visit and payment of the balance is your responsibility. Patients with overdue balances must pay them off before additional services are rendered

Who Can Discuss a Bill?:
Due to privacy concerns, our staff may only speak with the patient or the person designated in writing by the patient to receive or discuss the patient's bill(s). Please identify the individual(s) with whom our staff can discuss your bills on page 1 of the patient registration form.

Assignment of Payment:
I hereby authorize payment directly to Fresno and Visalia Dermatology Specialists of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

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Outside Services:
To provide the best care possible, Fresno and Visalia Dermatology Specialists, may, on occasion, send specimens to an outside source for processing. Examples of these services are pathology and laboratory testing. If we send specimens to an outside office, you will receive a separate billing statement from the outside pathologist or laboratory. These charges will be in addition to those services rendered by our offices.

Release of Information:
You hereby give consent to release to authorized persons financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

Cosmetic Procedures :
Elective cosmetic procedures and most laser treatments are not covered by insurance companies. You are financially responsible for all charges associated with elective, cosmetic and non-covered procedures. Patients who have a cosmetic consultation will receive credit in the amount of the consult fee toward their cosmetic procedure, if the cosmetic procedure scheduled and performed on the same day of the consultation or within three months if the consultation was for cosmetic surgery or liposuction.

Late Charges and Other Fees:
- Accounts with balances over 90 days old are subject to late fees.
- Accounts referred to a collection agency may be subject to a $50.00 collection fee, attorney fees, and/or the percentage allowed under California state law.
- There is a $25.00 fee for all checks returned for NSF (non-sufficient funds).

I have read, understand, and agree to the above Financial and Billing Policies. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Fresno and Visalia Dermatology Specialists. I authorize Fresno and Visalia Dermatology Specialists to release pertinent medical information to my insurance company when requested or when needed to obtain authorization for a procedure or to facilitate payment of a claim. I also authorize the release of pertinent medical information to the California Department of Insurance should a payment dispute arise between my insurance company and Fresno and Visalia Dermatology Specialists. I have given complete and accurate information and agree to inform Fresno and Visalia Dermatology Specialists of any changes regarding my personal billing information or my insurance billing information.

Patient Signature (Or signature by parent or guardian if patient is a minor) Date

FRESNO & VISALIA
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Notice of Privacy Practices

Carlos Paz, MD, PhD
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Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. HIPAA give you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information. This notice serves to explain how we will maintain the privacy of your health information and how we may disclose your personal information.

The patient understands that we may use and disclose your medical records for the following purposes:

- Treatment – for providing, coordinating, or managing health care and related services by one or more healthcare providers.
- Payment – for such activities as obtaining reimbursement for services, confirming coverage, billing, or collections activities.
- Health Care Operation – includes the business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service.
- The Practice may also be required or permitted to disclose your PHI for law enforcement and other state or federal record-keeping requirements.
- Unless you instruct us not to do so, we may contact you by phone, text, or email, to provide appointment reminders.

The following use and disclosure of PHI will only be made pursuant to us receiving a written authorization from you:

- Uses and disclosure of your PHI for marketing purposes.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances, which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alternative means.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

It is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

FRESNO & VISALIA
DERMATOLOGY
SPECIALISTS

Consent to Photograph

Carlos Paz, MD, PhD
Betsy McCarley Billys, MD
Rhonda Bonilla, FNP
Melissa Manriques, FNP
& Allison Smith, PA

This form is to be used only for photographs taken for treatment for Fresno Dermatology Specialists, Inc.'s own healthcare operations, as allowed under the Federal Privacy laws. Photography for other purposes (e.g., research, publication, outside education, marketing, public relations, news or documentary) requires use of a separate form, "Consent to Photograph and Authorization for Use and Disclosure."

The undersigned hereby consents to be photographed while receiving treatment at the office, with the understanding that the images from such photography may be used for the patient's treatment or for the office health care operations, such as medical review, peer review or medical education, as the treating health care provider(s) deem appropriate. The term "photograph" as used herein includes video or still photography, in digital or any other format, and any other means or recording or reproducing images.

Patient Signature (Or signature by parent or guardian if patient is a minor) Date