**LAMONT W. HORNBECK, M.D.**

CLINICAL DERMATOLOGY AND CUTANEOUS SURGERY

## PATIENT REGISTRATION

Name _____
Last First MI

Address _____
Street City State Zip

Telephone ( ) _____ ( ) _____ ( ) _____
Home Cell Work

DOB _____ SSN _____ Marital Status ☐S ☐M ☐ D ☐ W

Email _____ Gender ☐ Male ☐ Female

Emergency Contact _____
Last Name First Name Relation Phone Number

## INSURANCE INFORMATION

***Please present all your insurance card to the receptionist***

☐ **Self Pay (no insurance)**

Primary Insurance _____ Secondary Ins _____

Policy Holder _____ DOB _____

## PARENT, GUARDIAN, OR RESPONSIBLE PARTY (*if different from patient*)

Name _____ Relation to patient _____

DOB _____ SSN _____ Contact Number _____ ☐Home ☐Cell

Address ☐Same as above Alt. Address _____
Street City State Zip

Is this visit related to an injury at work? ☐YES ☐NO Are you currently employed? ☐YES ☐NO
Do you have any other health coverage? ☐YES ☐NO Have you ever served in the military? ☐YES ☐NO

## TELEPHONE COMMUNICATION RELEASE

May we leave medical information on your home answer machine? ☐ YES ☐ NO
May we leave medical information on your cell voicemail? ☐ YES ☐ NO
May we discuss your medical information with family members? ☐ YES ☐ NO
If yes, please list: _____
Phone

### Authorizations

I request that payments of authorized benefits be made on my behalf to the provider for any services furnished to me.
I authorize my provider and staff to view and send my prescription to
I authorize any holder of medical information about me to release to the above listed insurance companies and their agents any information needed to determine these benefits payable for related services.
I have received/or reviewed a copy of the Notice of Privacy Practices from Lamont W. Hornbeck MD, Inc.

**Signature** _____ **Date** _____
Patient/Responsible Party

**729 Sunrise Avenue ▪ Suite 700 ▪ Roseville, CA 95661 ▪ 916.782.3721 ▪ Fax 916.782.0618**

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## FINANCIAL POLICY

As a service to you, we will bill your insurance carrier(s) provided to us. Please keep in mind that your insurance policy is basically a contract between you and your insurance company. However, you are ultimately responsible for the payment of services. If an insurance carrier has not paid within 60 days, you may be responsible for paying any outstanding balances. It is your responsibility to pay for any applicable deductibles, co-payments, co-insurance, or non-covered/cosmetic services on the day of the appointment.

- Payments are due at the time of service.
- Payment for private pay patients, cosmetic, or non-covered services are due at the time services are rendered.

There is a $25 charge for checks returned for insufficient funds. If past due bills are sent to collections, payments must be made directly to the collection agency.

## PARTICIPATING PLANS

Insurance coverage is not a guarantor of payment. As your insurance is a contract between you and your insurance carrier, it is your responsibility to know your coverage eligibility, deductibles, copays, and network requirements. Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances. We cannot legally discount fees after their submission on your behalf to the carrier and writing off balances could jeopardize our contract with your carrier. We are legally obligated to collect the patient responsibility: co-insurances, co-payments, or deductibles under the term of the Anti-Kickback laws.

## NON-PARTICIPATING PLANS:

**Dr. Hornbeck is not contracted with any HMO or MediCal lines of business/insurances. It is against the law for Dr. Hornbeck to treat MediCal patients in exchange for direct payment. It is also against the law for MediCal patients not to inform the provider of their MediCal status. If you obtain MediCal insurance during your care, our office will have to discontinue further/future treatment and we will forward your records to your new Dermatologist. Therefore, by initialing this section, you are attesting that you do not have MediCal insurance.** **Initials_____**

### LABORATORY & PATHOLOGY SERVICES

Specimens from biopsies surgical procedures collected in our office are sent an outside laboratory or possibly pathology service for analysis. While we do our best, we cannot always determine which laboratory or pathologist are in-network with your coverage. You may be responsible for laboratory and pathology charges. Please let our office staff know if there is a designated laboratory that your insurance prefers.

### MEDICAL RECORDS

Copies of your medical records may be obtained with written consent. The charge for this service is $15.00. Please keep in mind; you may be responsible for any charges incurred from any external copying services or physicians for medical records obtained.

### MISSED APPOINTMENTS

Our office request a 24-hour cancellation notice for office visits and 48-hour cancellations notice for surgical procedures. **Failure to cancel an office visit will result in a $25 fee and a $75 fee for surgical or cosmetic procedures.** All cancellations/no show fees must be paid prior to having another visit with our office.

### MEDICATIONS AND REFILLS

Please contact your pharmacy for prescription refills and allow at least 2 business days to process medication refill requests.

By my signature below, I have read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by our practice as needed.

**Signature** _____ **Date** _____

Patient/Responsible Party

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# Medical History (For Dermatology Appointment)

Patient Name: _____ Date of Birth: ___/___/___ Today's Date: ___/___/___

List all medications and dosage you are currently taking:
1: _____
2: _____
3: _____
4: _____
5: _____

List all topical medications (creams, etc.) you are using:
1: _____
2: _____
3: _____
4: _____
5: _____

## SKIN HISTORY:

Have you ever visited a dermatologist? □ Yes □ No When? _____ Reason? _____

Have you ever had skin cancer? □ Yes □ No If yes, what kind? _____

Do you have a history of any other skin diseases? □ Yes □ No If yes, explain: _____

## GENERAL MEDICAL: Do you have now, or have you ever had:

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Asthma | □ | □ | Seizures | □ | □ | Arthritis | □ | □ |
| Seasonal Allergy | □ | □ | Depression | □ | □ | Ulcers/ Reflux | □ | □ |
| High Blood Pressure | □ | □ | Thyroid Disease | □ | □ | Lip/Fever Blisters | □ | □ |
| Heart Valve Disease | □ | □ | Diabetes | □ | □ | HIV Infection | □ | □ |
| Phlebitis | □ | □ | Glaucoma | □ | □ | Cancer | □ | □ |
| Blood Clots | □ | □ | Cataracts | □ | □ | Hepatitis | □ | □ |
| Measles | □ | □ | Pneumonia | □ | □ | Colitis/ Bowel Disease | □ | □ |
| Polio | □ | □ | Tuberculosis | □ | □ | Gallbladder Disease | □ | □ |

Drug allergies? □Yes □No Please list: _____ Food allergies? □Yes □No Please list: _____

List any surgical procedures you have had:

Type of Surgery _____ Date: _____ Type of Surgery _____ Date: _____

Type of Surgery _____ Date: _____ Type of Surgery _____ Date: _____

## SOCIAL HISTORY:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Do you smoke cigarettes? | □ | □ | Do you drink alcohol? | □ | □ |
| Have you ever had local or dental anesthesia? | □ | □ | Do you need to take antibiotics before dental appointments? | □ | □ |
| Any bad reaction? | □ | □ | Are you pregnant or breastfeeding? | □ | □ |

What is your occupation? _____

## FAMILY HISTORY:

Do you have any family history of skin cancer, melanoma, or skin disease? □ Yes □ No If yes, what type? _____

| | If Living | | If Deceased | |
|---|---|---|---|---|
| | Age | Health | Age at death | Cause |
| Father | | | | |
| Mother | | | | |
| Sibling 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Completed by: _____ Date: _____
Patient/ Parent (Signature)

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# PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing **Lamont Hornbeck, MD INC** as your healthcare provider for your Dermatologic needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this to acknowledge your understanding of our patient financial policies in effect as of 1/1/2021.

**Patient Financial Responsibilities**

The patient (patient's guardian, if a minor or responsible for patient care) is ultimately responsible for the payment for treatment and care.

We are happy to bill your insurance for you, however, the patient is required to provide the most correct and updated information regarding your insurance.

Patients are responsible for payment of co-pays, co-insurance, deductibles, and all other procedures and/or treatments not covered by their insurance plan.

Co-pays are due at the time of service.

Co-insurance, deductibles and non-covered items are due **30 days** from receipt of billing.

Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include but not limited to:

Charge for returned checks
Charge for missed appointments without 24 hours' notice

By my signature below, I hereby authorize assignment of financial benefits directly to **Lamont Hornbeck, MD INC**, and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

**I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.**

**Patient Name**

Signature of patient or guardian

Date

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## SECOND OPINION CONSULTATION AND SPECIAL STAIN NECESSITY

I authorize and request my treating physician, Dr. Lamont Hornbeck, M.D., to provide Pacific Dermatology, a healthcare provider of anatomic laboratory services, with a test order for a consult interpretation and report concerning your prior pathology specimen(s) collected and reported by Dr. Lamont Hornbeck, M.D.

Please keep in mind, some questionable slides require additional stains and/or a consultation from colleagues achieve a diagnosis for the benefit of the patient and provide the highest standard of patient care; however, this will not apply to most pathology readings by Dr. Lamont Hornbeck.

I agree to pay Pacific Dermatology Consultants' fee for the second opinion consult. I also consent to providing a copy of the consult report to the original pathologist and special stains will usually be ordered from DPMG or the HistoPath corporations.

| Patient's Name (Printed): | Patient's DOB | Phone Number |
|---|---|---|

| Signature of Patient<br>Or patient representative if patient is a minor or an adult unable to sign this form. | Date |
|---|---|


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By law, we now must send all your prescriptions electronically. There will no longer be any paper prescriptions given to you. We are asking for the name and phone # of your pharmacy, if you have the address or cross street, that would be helpful. Any script that is given by Dr. Hornbeck will be issued to your pharmacy of choice; you may inquire with them as to when it will be ready for you.

Thank you,

Dr. Hornbeck and staff

PATIENT NAME_____
PHARMACY_____
PHARMACY ADDRESS_____
PHARMACY PHONE NUMBER_____

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To: Our Valued Patients:

There will be a few changes this new year, having to do with insurance and billing.

We had so many issues last year with a few insurance companies that we have decided to bill your insurance once for each visit; if they ask for records, we will gladly send them, but only once! If no payment is received within 45 days, we will then have to send you a statement.

We apologize that we must do this, but some insurance companies are not paying in a timely manner or not at all. If you do end up getting a statement from us, we, of course, will give you 30 days to correct the issue with your insurance company. We have found that they tend to listen to the patient more than the provider.

Your insurance may not be the one that we are having issues with, so this will not affect you. If you would like to know if yours is one that we are trying to retrieve payment from, please do not hesitate to ask. Also, if you choose to find another dermatologist, we will understand and offer a copy of your records if you need them.

By signing below, you are acknowledging you have received this letter and that you do not have Medi-cal of any form as your primary or secondary insurance. Unfortunately, we are not able to see you if this is your primary or secondary insurance. We will gladly give you a copy of this form for your records if you wish.

We value you as our patient and wish you continued good health in 2023!

Thank you,

Lamont Hornbeck, MD, and staff

Printed Name_____

Signature_____Date_____