Pierre G. Labrecque, M.D.
120 North Miller Street, Building C ▪ Santa Maria, CA 93454
(805) 739-0033 Office
(805) 739-1712 Fax

Welcome to DermaSpa MED and thank you for entrusting us with your medical needs. Your care and satisfaction is our priority and we are committed to providing you with the best! That's why we are excited to announce changes in the way we provide services.

As part of our dedication to quality medical care, we are transitioning to an electronic health record (EHR) system. EHRs are proven to increase patient care, privacy and medical records accuracy while maximizing office efficiency. As a result, you will continue to receive safe and appropriate healthcare in an environment that has the added benefits of modern technology.

There are many added benefits to EHR that will improve your experience. This improvement to our practice ensures that your medical information is safely stored in an encrypted database with limited access. You will also experience reduced waiting times with e-prescriptions, prompt reporting to your referring physician and digital photographs saved in your chart.

During the EHR implantation you may experience delays in service. For example, it may take a few extra minutes in gathering information prior to seeing Dr. Labrecque, or the staff to prepare for a procedure in the room. We assure you these delays are temporary.

Please help us maintain continuity of care by providing your most current information, including medical history and insurance coverage for your electronic file.

If you have any questions or concerns, please do not hesitate to ask a staff member. Thank you for your patience and we are confident that this technology will enable us to continually enhance the value of healthcare services we provide to you by cutting cost and increasing quality of care.

Sincerely,

Dr. Labrecque and Staff

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Race	Ethnic Group
☐ White	☐ Not Hispanic or Latino
☐ American Indian or Alaska Native	☐ Hispanic or Latino
☐ Asian	☐ Unknown
☐ Black or African American	☐ Unspecified
☐ Native Hawaiian or Other Pacific Islander	
☐ Other Race	
☐ Unspecified	

Preferred Language: _____

PATIENT HISTORY INFORMATION

Name			Date of Birth		Age
	First *Middle* *Last*				
Marital Status	☐ S ☐ M ☐ W ☐ D		Gender:	☐ M ☐ F	
Address			Home Phone		
City, State, Zip			Cell Phone		
Employer			Work Phone		
Employer Address			Occupation		
Drivers License #		SSN			
Name of Responsible Party			Relationship		
Address			Home Phone		
City, State, Zip			Cell Phone		
Employer			Work Phone		
Employer Address			Occupation		
Drivers License #		SSN			

INSURANCE INFORMATION

Primary Insurance			Policyholder Name		
Policyholder DOB			Policyholder SSN		
Group #		Policy #		Effective Date of Coverage	

SECONDARY INSURANCE INFORMATION

Secondary Insurance			Policyholder Name		
Policyholder DOB			Policyholder SSN		
Group #		Policy #		Effective Date of Coverage	

REFERRED BY

Name		Phone Number	

IN CASE OF EMERGENCY CONTACT (RELATIVE OR FRIEND)

Name		Phone	
Relationship		Work Phone	

I understand I am financially responsible for payment in full of all accounts with the exception of industrial injuries or fully sponsored government accounts. I hereby authorize my doctors to release records to other doctors or legitimate requesting sources. I authorize payment of medical benefits to my physicians or suppliers for services rendered. A photocopy of this authorization and assignment of benefits shall be as valid as the original.

_____ _____

Patient/ Parent of Minor/Guardian Signature **Date**

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Patient Name: _____

HISTORY and INTAKE FORM

Past Medical History: (please check all apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ BPH
- ☐ Bone Marrow
- ☐ Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Valve Replacement
- ☐ None

Other: _____

Past Surgical History: (please check all apply)

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

Other: _____

DERMA Spa MED

Patient Name: _____

Skin Disease History: (Please check all apply)

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy/Poison Oak
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ None

Other: _____

Do you use Sunscreens? ☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Medications: (Please enter all current medications)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

Social History: (Please check all apply)

- ☐ Currently Smokes – daily
- ☐ Currently Smokes – not daily
- ☐ Has smoked in the past
- ☐ Has never smoked
- ☐ Drug Use
- ☐ None

Other: _____

Preferred Pharmacy

Name of Pharmacy: _____

Street Address: _____

City: _____

Phone Number: _____

_____ _____

Patient/ Parent of Minor/Guardian Signature **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I was offered a copy of this medical office's Notice of Privacy Practices dated September 1, 2003. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I can request a copy of the current Notice of Privacy Practices at any time. A copy of any amended Notice of Privacy Practices will be available at each appointment.

NEW PATIENTS

☐ I am declining a copy of the Notice of Privacy Practices at this time, but will acknowledge that I can request a copy at any time.

☐ I have received a copy of the Notice of Privacy Practices.

ESTABLISHED PATIENTS

☐ I am declining a copy of the Notice of Privacy Practices amended on September 1, 2003 at this time, but acknowledge that I can request a copy at any time.

☐ I received a copy of the amended Notice of Privacy Practices dated September 1, 2003.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate the relationship:

☐ Parent or guardian of minor patient.

☐ Guardian or conservator of an incompetent patient.

Name and address of patient: _____
_____
_____
_____

DERMA Spa MED

Patient Name: _____

Review of Systems: Are you currently experiencing any of the following?
(Please check all that apply)

- ☐ Allergy to Latex
- ☐ Allergy to Lidocaine
- ☐ Problems with bleeding
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Problems with healing
- ☐ Allergy to adhesive
- ☐ Allergy to topical antibiotic ointments
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Blood thinners
- ☐ Artificial heart valve
- ☐ Premedication prior to procedures
- ☐ Changing mole
- ☐ Pregnancy or planning a pregnancy
- ☐ Rapid heart beat with epinephrine
- ☐ Yeast infections with antibiotics
- ☐ GI upset with antibiotics
- ☐ Immunosuppression
- ☐ Rash
- ☐ Abdominal pain
- ☐ Artificial joints within past two years
- ☐ Anxiety
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Blurry vision
- ☐ Chest pain
- ☐ Cough
- ☐ Depression
- ☐ Fever or Chills
- ☐ Headaches
- ☐ Hay Fever
- ☐ Joint Aches
- ☐ Muscle Weakness
- ☐ Neck Stiffness
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sore Throat
- ☐ Thyroid Problems
- ☐ Unintentional Weight Loss
- ☐ Wheezing
- ☐ Other Symptoms: _____
  _____

_____ _____

Signature Date

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CONSENT FOR TREATMENT OF A MINOR

As the parent/legal guardian of _____,
I hereby consent to and authorize the administration of all treatments that may e considered advisable and necessary in the judgment of the physician. I consent to X-ray examinations, laboratory procedures, medical treatment, EKG or services rendered under the instructions of the physician. I understand that I am financially responsible to the physician. I authorize payment of all medical benefits to the physician.

I here certify that the above information is true and correct to the best of my knowledge.

Date: _____

Print Name:_____

Signature:_____

Witness:_____

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FINANCIAL RESPONSIBILITY STATEMENT

As you are aware, the nature of insurance rules and regulations is more complex than ever. Here at DermaSpaMED, we are actively involved with hundreds of insurance companies, EPO's and PPO's, each with its own set of rules that may or may not change on a regular basis. Although we attempt to keep abreast of common changes, you will be responsible for any charges incurred that are denied due to lack of compliance with your insurance company. Please become familiar with your insurance plans regulations.

1. If you are assigned to a Primary Care Provider (PCP), ALL visits and procedures must be PRE-AUTHORIZED prior to your visit, unless stated by your insurance plan. Even if one visit was approved, subsequent visits and follow-up visits may need additional approval, even for treatment of the same diagnosis. Verify this information at the time of your visit.
2. If your insurance company requires that your laboratory testing be sent to a specific lab, please be sure to tell the medical assistant so we can comply with these requirements.
3. Appointments must be cancelled 24-hours in advance to avoid a $50.00 cancellation/no-show fee, and a $250.00 fee if the appointment is for a procedure (Skin surgery, Lasers, etc.)
4. You are responsible for non-Medicare approved expenses. Medicare supplements may need pre-authorization.
5. Our office in not contracted with State MediCal. Therefore, services will not be submitted to State MediCal for payment and you will be financially responsible far any patient designated balances. By signing this agreement, you will be waiving your State MediCal benefits.
6. Co-payments and outstanding balances will be collected PRIOR to being seen. Unmet deductibles are expected to be paid in full at the time services are rendered.
7. If your insurance delays payment or denies payment of your claim, we may need to contact the Insurance Commissioner on your behalf. By signing this agreement, you are giving DermaSpaMED permission to do so.
8. Bring in any necessary information to assist us in billing your insurance (i.e. copy of your insurance card, authorization or referral from your primary care physician – if required by your insurance policy).
9. Patients with no insurance will be expected to pay for the initial visit in full, as well as further visits, unless arrangements have been made. Any patient with a poor credit history with Dr. Labrecque will be expected to pay prior to being seen.

Again, we at DermaSpaMED strive to assist you through our billing coordinator. Thank you, and please sign below to acknowledge your acceptance of these policies.

Patient Signature: _____ Date: _____

Staff Member for Dr. Labrecque: _____ Date: _____