VAFAIE DERMATOLOGY Intake Form

Patient Information

First Name | Middle | Last

Sex Male / Female | Date of Birth _ _ / _ _ / _ _ _ _ Age _ _ | SSN _ _ _ - _ _ - _ _ _ _

Address | City | State | Zip _ _ _ _ _

Home Phone _ _ | Mobile Phone _ _ | Email

If we need to get in touch with you regarding your test results M-F, 8-5, what is the best way to reach you?

Primary Care Physician | Primary Care Physician Phone _ _

Pharmacy | Pharmacy Phone _ _

Pharmacy Address

Referred by

Reason for this visit to dermatologist

Personal / Family Medical History

Have You Experienced:	In yourself?	In your family?	*(Specify who)*
Skin Cancer	**Y / N**	**Y / N**	
Other Cancer	**Y / N**	**Y / N**	
Eczema / Psoriasis (Circle one)	**Y / N**	**Y / N**	
Seasonal Allergies; Asthma; Hay fever	**Y / N**	**Y / N**	
Difficulties with bleeding or clotting	**Y / N**	**Y / N**	
Difficulties with scarring or keloids	**Y / N**	**Y / N**	

Female patients: please inform your doctor if you are or plan on becoming pregnant during your treatment period. **Y / N**

Please list all other conditions for which you are currently receiving treatment:

Past surgical history / hospitalizations and dates:

Please list all medications you are currently taking:

Allergies / Adverse Reactions

Food Allergies: _____

Medication Allergies *(please list reaction, if known):*_____

Have you ever used a sun tanning booth? **Y / N** How often do you go? _____

Do you have any other potential interests? (such as...)

Chemical Peels	**Y / N**
Laser for acne scarring, blood vessels, sun damage, other	**Y / N**
Body sculpting & permanent fat cell reduction	**Y / N**
Injectables (filler, botox)	**Y / N**
Treatments for spider veins	**Y / N**
Other: (please specify)	

Patients: Please fill in date this form was completed: Month _ _ / _ _ / _ _ _ _

Vafaie Dermatology
Janet Vafaie, MD.,F.A.A.D
Board Certified Dermatologist
Medical, Cosmetic, Laser and MOHS/Skin Cancer Surgery

I voluntarily give my consent for treatment and also my consent to any procedures that Dr. Janet Vafaie performs in the dermatology clinic and deems necessary for my condition, which include but are not limited to: cryosurgery (freezing of skin lesions with liquid nitrogen), incision and drainage of abscesses and cysts, Excision of the skin, removal of skin tags, shave biopsy and punch biopsy of skin lesions and rashes, debridement of wounds, Steroid Injections (will discuss risk and benefits), injection of skin lesions, cauterization of skin lesions. The Doctor will also be performing Cosmetics Botox, Filler and Laser Treatments. Dr. Janet Vafaie will discuss in detail any procedure she plans to perform, answer all questions relating to the procedure and obtain oral informed consent in the exam room.

Signature of Patient or Legal Guardian Date

Printed Name of Patient or Legal Guardian Relationship to Patient

Signature of Witness Date

Notice of Privacy Practices

This notice informs you how your medical information may be used by our office. Please carefully review this notice.

We at Vafaie Dermatology realize that information about you and your health is personal. As a provider of health care, Health Insurance Portability and Accountability Act of 1996 - HIPAA law further requires that we:

- protect the privacy of your health information;
- observe the terms of this Notice and any future Notice; and
- furnish you a copy of this Notice.

When we may not use or disclose your health information

Except as described in this Notice, we will not use or disclose your health information without your written authorization.

How Vafaie Dermatology may use or disclose your health information

Vafaie Dermatology will protect the privacy of your health information. For some purposes, we must have your written authorization to use or disclose your health information. However, law permits us to use or disclose your health information in certain instances without your authorization.

Examples of permitted disclosures are:

For Treatment. We will use your personal health information to treat you or disclose your health information to other persons who are involved in your care.

For Payment. We may use or disclose health information to submit a claim to or receive payment from your insurance company or third party.

For Health Care Operations. We may use or disclose health information about you for the purposes of operations.

As Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and/or disclose your health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Public Health Risks.

We may disclose your health information for public health activities which generally include:

- disease prevention or control;
- reporting medication reactions;
- to notify patients of product recalls;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we strongly believe a person has been the victim of abuse, neglect, or domestic violence;
- We may disclose health information to a health agency for activities authorized by law. These oversight activities, which monitor the health care system, include cancer registry audits, investigations, inspections, and licensure;
- We may disclose your health information in response to an administrative or court order if you are involved in a lawsuit or dispute.

You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to a restriction that you request. If we do agree, we will put the agreement in writing and abide it, except in emergency situations. We cannot agree to limit the uses or disclosures of information that are required by law. You have the right to inspect or have a copy of your health information. You must submit a written request to us. Request forms are available through our medical records department. We may charge a fee for the costs of copying, mailing or other supplies that are necessary to grant your request. You have the right to request that we amend health information that you may consider incorrect or incomplete. You must submit a written request for an amendment. The request for an amendment form is available through our medical records department. We are not required to amend health information that is accurate and complete. We will provide you with information about the procedure for addressing any disagreement with a denial to amend.

Vafaie Dermatology
Janet Vafaie, MD.,F.A.A.D
Board Certified Dermatologist
Medical, Cosmetic, Laser and MOHS/Skin Cancer Surgery

Acknowledgment of Receipt of our Notice of Privacy Practices

Vafaie Dermatology Notice of Privacy Practices has been provided to me for review. I understand that the purpose of this notice is to inform me of my rights in regard to my Protected Health Information and also the ways in which Vafaie Dermatology may use my Protected Health Information.

Patient (or Patient's Legal Representative) Signature Date

Patient Name Chart # Date

VAFAIE DERMATOLOGY Intake Form

JANET VAFAIE MD

10921 WILSHIRE BLVD STE 800 LOS ANGELES, CA 90024
23440 CIVIC CENTER WAY STE 204 MALIBU, CA 90265
TELEPHONE: 310-443-4040 FAX:310-443-4080
NPI:1942465232

Date: _____

For All Patients:

This letter is to confirm that I, the patient, called my insurance company to confirm that Dr. Janet Vafaie MD is a contracted provider with my specific, individual insurance plan. I understand that my insurance will be billed, but I am responsible for all visit and procedure costs that my insurance does not cover. Any services not covered will be billed as a balance to the patient. Dr. Janet Vafaie will be working with patients on an individual basis.

I understand that I am responsible for determining if Dr. Janet Vafaie MD in network with my particular insurance plan and agree to cover costs not covered by my insurance.

Signature _____ Date_____

Print Name_____