

**Please print all information and fill in all blanks**

**Today's Date:** \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_

Last
First
Mid. Int.

Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Sex     Male     Female /     Married     Single     Widowed     Separated     Divorced

Birth Date \_\_\_\_\_ Email \_\_\_\_\_

Would you like to receive our quarterly e-newsletter for special offers and skincare updates?

Yes     No

Occupation \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

In Case of Emergency \_\_\_\_\_ Phone Number \_\_\_\_\_

Relationship \_\_\_\_\_ Primary Physician \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Phone/Fax \_\_\_\_\_

**INSURED OR PERSON FINANCIALLY RESPONSIBLE**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_

Occupation of Insured \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

*Please show your insurance identification card to the receptionist so that she can make a copy.*

Insurance Company \_\_\_\_\_ Member ID# \_\_\_\_\_

**REFERRAL**

Who may we thank for having referred you to Dr Goodlerner

Internet (Which Website) \_\_\_\_\_

Insurance Book

Physician (Name) \_\_\_\_\_

HMO

Friend/Family (Name) \_\_\_\_\_

SBC/ Verizon Yellow Pages

News Paper Ad (Which One) \_\_\_\_\_

Other \_\_\_\_\_

**PATIENT AUTHORIZATION & ASSIGNMENT**

*I hereby authorize Susan Goodlerner, M.D. to furnish my insurance company with all information concerning my illness or injury. I hereby assign payment of all benefits to which I am entitled directly to Susan Goodlerner, M.D. for services rendered and/or related to medical expenses. I understand and agree that I am financially responsible for all charges whether or not covered by insurance. A photocopy of this authorization/assignment may serve as the original.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

23451 Madison Street, Bldg. 7, Suite 330  
Torrance, CA 90505  
Phone (310) 375-9994 Fax (310) 375-0789

## COMPLAINT AND HISTORY INFORMATION

What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_

How long has the problem(s) bothered you? \_\_\_\_\_  
\_\_\_\_\_

Other medical conditions for which you have been treated (current or prior) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you pregnant?  Yes \_\_\_\_\_ months  No  Not Applicable

Previous surgical operations (list dates) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you been required to take antibiotics before dental or surgical procedures? \_\_\_\_\_

If so, which one? \_\_\_\_\_

List all allergies \_\_\_\_\_  
\_\_\_\_\_

Health of family members – include related skin conditions \_\_\_\_\_  
\_\_\_\_\_

Current medications (include birth control pills, vitamins, over-the-counter medications)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have previously used these medications and over-the-counter products for my skin condition  
\_\_\_\_\_  
\_\_\_\_\_

What type of work do you do? \_\_\_\_\_

What hobbies do you have? \_\_\_\_\_



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## OFFICE POLICIES

**Payment Policy:** Patients are responsible for all copays and amounts applied to insurance deductibles at the time of service. Past due balances are also payable at the time of service. We will attempt to verify insurance coverage, copay and deductible amounts prior to each visit. It is the patient's responsibility to bring their insurance card and forms, if appropriate, to the initial visit and to advise us immediately of any insurance changes. We will be happy to bill Medicare and all insurance for which we are a provider. Prior to all surgical procedures, we will advise of the charges and of your financial responsibility. The patient will be requested to pay their portion on the day of surgery. Patients are responsible for any balances not paid by insurance. If your insurance has been terminated prior to your visit, you will be billed for the charges. All patient responsibility balances not paid by 120 days will be sent to collections.

**Appointments:** If you are unable to make an appointment at your scheduled time, please advise us at least 24 hours in advance. We will assist you with a reminder call 2 nights prior to your scheduled appointment. Please provide us with a daytime and evening number where you can be reached on that day. **While we understand that unforeseen circumstances may require you to miss an appointment or postpone at the last minute, we reserve the right to charge for missed appointments or appointments cancelled with less than 24 hours notice. We will refuse to schedule an appointment for any patient after three such incidents.**

**Returned Checks:** There will be a \$25.00 charge for returned checks. The patient will then be required to pay with cash or money order within 10 days to avoid collections actions.

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Signature of Patient or Responsible Party

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Date



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**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, Susan Goodlerner, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Susan Goodlerner, M.D. Notice of Privacy Practices for a more completed description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Susan Goodlerner, M.D. reserves the right to refuse its Notice of Privacy Practices at anytime.

A revised Notice of Privacy Practices may be obtained by forwarding a written request to Susan Goodlerner, M.D. Privacy Officer at 23451 Madison Street Building 7, Suite 330 in Torrance, CA 90505.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Susan Goodlerner, M.D. may decline to provide treatment to me.

I understand that as a part of Dr. Goodlerner’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Can confidential messages be left on your answering machine or voicemail? ( ) YES ( ) NO

Please list, if any, person(s) whom we may inform about your medical condition, diagnosis, and/or financial account:

Name/Relation: \_\_\_\_\_ Phone Number \_\_\_\_\_

Name/Relation: \_\_\_\_\_ Phone Number \_\_\_\_\_

I wish to have the following restrictions to the use or disclosure of my health information:

\_\_\_\_\_

I fully understand and ( ) accept ( ) decline the terms of this consent.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date



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## **MUTUAL AGREEMENT**

Dr. Susan Goodlerner (labeled "Physician") agrees to provide treatment to: \_\_\_\_\_ ("Patient"). The Physician takes pride in being able to extend a greater degree of privacy than is required by law.

Federal and State privacy laws are complex. Unfortunately, some medical offices try to find loopholes around these laws. For example, physicians are forbidden by law from receiving money for selling lists of patients or medical information to companies to market their products or services directly to patients without authorization. Some medical practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Physician believes this is improper and may not be in the patients' best interest. Accordingly, Physician agrees not to provide medical information for the purpose of marketing directly to Patient. Regardless of legal privacy loopholes, Physician will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

We want your feedback. If our office gets it right, tell us. If we could do something better, tell us. We take quality improvement seriously. While there are scores of "rating sites" in cyberspace, many fail to provide useful information. Let's get it done right. We can make recommendations as to which sites follow minimum standards for fairness and balance. Just ask us.

Physician has invested significant financial and marketing resources in developing the practice. Nothing in this Agreement prevents a patient from posting commentary about the Physician - his practice, expertise, and/or treatment - on web pages, blogs, and/or mass correspondence. In consideration for treatment and the above noted patient protection, if Patient prepares such commentary for publication on web pages, blogs, and/or mass correspondence about Physician, the Patient exclusively assigns all Intellectual Property rights, including copyrights, to Physician for any written, pictorial, and/or electronic commentary. This assignment shall be operative and effective at the time of creation (prior to publication) of the commentary.

This Agreement shall be in force and enforceable for a period of five years from Physician's last date of service to Patient. As a matter of office policy, Physician is requiring all patients in its practice sign the Mutual Agreement so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Physician's patients. Further, this Agreement will survive for a minimum of three years beyond any termination of the Physician-Patient relationship.

Patient and Physician acknowledge that breach of this Agreement may result in serious, irreparable harm. Patient and Physician agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

SO AGREED THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, 2010 \_\_\_\_\_ (PATIENT SIGNATURE)