LAWRENCE S. MOY, M.D. INC.

DERMATOLOGY AND DERMATOLOGY SURGERY

1101 N. SEPULVEDA BLVD., SUITE 100, MANHATTAN BEACH, CA 90266

Referred By ___________________________ Friend Relative Doctor Co-Worker Newspaper Ad Other

PATIENT INFORMATION *(Please fill out all information in **black or blue** ink)*

Last Name__________________________First Name_______________________ M.I. ___________ Sex: M / F
Address____________________________City_____________________State_____________Zip___________
Home Phone (___)_____________Mobile Phone (___) __________________Work Phone (___)__________
Date of Birth ____/____/________Soc. Sec. No._________________Driver's License #________________
Employer___________________________Occupation____
Address____________________________City_____________________State_____________Zip____________
E-mail

PARENT (if patient is a minor) **OR SPOUSE INFORMATION**

Last Name__________________________First Name________________________________M.I.___________
Address____________________________City_____________________State_____________Zip____________
Home Phone (___)_____________Mobile Phone (___) ____________Work Phone (___)________________
Date of Birth ____/____/________Soc. Sec. No._________________Driver's License #________________
Employer___________________________Occupation____
Address City State Zip

1st INSURANCE

Policy Under: Self Spouse Parent Other
Insurance Co.____
ID Number________________________________Group Number______________________________________
Name of Insured Birth date of Insured Insured SS#

2nd INSURANCE

Policy Under: Self Spouse Parent Other
Insurance Co.____
ID Number________________________________Group Number______________________________________
Name of Insured Birth date of Insured Insured SS#

PLEASE **READ** AND **INITIAL** (ACKNOWLEDGING) THE FOLLOWING **(6 total)**

_______ I HEREBY AUTHORIZE EXAMINATION AND SERVICES BY LAWRENCE S. MOY, M.D., INC.

_______ I HEREBY ASSUME FULL RESPONSIBILITY FOR ANY MEDICAL BILLS INCURRED IN THIS OFFICE. I FURTHER UNDERSTAND THAT PAYMENT OF THESE BILLS IS NOT CONTINGENT UPON ANY INSURANCE COVERAGE I HAVE OR MIGHT OBTAIN. PLEASE FEEL FREE TO DISCUSS FEES WITH YOUR DOCTOR PRIOR TO ANY TREATMENT OR SERVICE.

_______ I UNDERSTAND THAT I AM REQUIRED TO PAY CO-PAY AT TIME OF SERVICE AND FOR ALL CHARGES ON THE DATE SERVICES ARE RENDERED. UNLESS A PPO OR GOVERNMENT SPONSORED HEALTH PLAN, IN WHICH THE PHYSICIAN IS A PARTICIPATING PROVIDER AND I AM BEING SEEN FOR A SERVICE I KNOW TO BE COVERED BY MY POLICY.

_______ I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO MY INSURANCE COMPANY NECESSARY TO PROCESS THE CLAIM. I HEREBY AUTHORIZE LAWRENCE S. MOY, M.D., INC. TO APPLY FOR PAYMENT ON MY BEHALF FOR COVERED SERVICES RENDERED BY HIM OR BY HIS ORDER. I REQUEST THAT PAYMENT BE MADE DIRECTLY TO LAWRENCE S. MOY, M.D., INC.

_______ I FURTHER UNDERSTAND THAT MY FAILURE TO APPEAR AT A SCHEDULED APPOINTMENT WITHOUT 24-HOUR CANCELLATION IS SUBJECT TO A **$50 FEE**, A FAILED SURGERY APPT IS A **$100 FEE.** IF THE BANK RETURNS MY CHECK UNPAYABLE, I WILL BE CHARGED A $25.00 SERVICE FEE, WHICH WILL BE DUE AND PAYABLE WITHIN THREE DAYS ALONG WITH THE AMOUNT OF THE ORIGINAL CHECK.

_______**I AGREE TO PAY MY COPAYS AT THE TIME OF SERVICE** OR INCUR A $10 FEE. **I FURTHER AGREE TO PAY MY PATIENT PORTION OF MY BILL WITHIN 15 DAYS OF RECEIPT OF MY BILL** OR WILL BE SUBJECT TO A 10% INTEREST FEE.

PATIENT SIGNATURE ____DATE: _______________

(PARENT OR GUARDIAN SIGNATURE IF PATIENT IS A MINOR)

Patient Name: ________________________________

LAWRENCE S. MOY, M.D. INC. DOB: ______________
1101 N. SEPULVEDA BLVD., SUITE 100, MANHATTAN BEACH, CA 90266

REASON(S) FOR VISIT: (List your concern in order of importance)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

CHILDHOOD DISEASES/PAST ILLNESSES:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

MEDICATIONS:

Please list all medications you are NOW taking. Be sure to include such things as aspirin, laxatives, birth control pills, insulin, and vitamins.

	NAME	FREQUENCY	DATE STARTED
1.			
2.			
3.			
4.			
5.			

MEDICATION ALLERGIES: (If unknown or none, please write NKDA: No known drug allergies)

______________________________ ______________________________

______________________________ ______________________________

HIPAA

*We may need to contact you with results. Please fill in the best 2 phone numbers to reach you and choose **ONE** corresponding preference in order for us to keep your information confidential.*

#1 phone number: (_____) _____-_______

Yes, please leave a detailed message.

Please leave a message for me to return your call and nothing more.

Contact me here only in the case of an emergency.

#2 phone number: (_____) _____-_______

Yes, please leave a detailed message.

Please leave a message for me to return your call and nothing more.

Contact me here only in the case of an emergency.

Please list names of any person(s) we can leave information with. Please be sure to check a box so we can give them the correct amount of information. You do not have to list any, if that is your desire.

First: ____________________ Last: ____________________ Alternate number: (_____) _____-_______

Yes, please leave a detailed message.

Please leave a message for me to return your call and nothing more.

Contact only in the case of an emergency.

First: ____________________ Last: ____________________ Alternate number: (_____) _____-_______

Yes, please leave a detailed message.

Please leave a message for me to return your call and nothing more.

Contact only in the case of an emergency.

Patient Signature: ____ Date: _____/_____/_____

Patient Name: ______________________________ DOB: ___________

LAWRENCE S. MOY, M.D. INC.
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MANHATTAN BEACH, CA 90266

LawrenceMoyMD
THERAPEUTIC SKINCARE

Patient-Office Consent

In an effort to make your experience with us a pleasant one, and to provide the best service possible, we ask that you read the following information sheet carefully to familiarize yourself with our current office policies. Please **initial** anywhere you see a "X_______" verifying that you have read and agree to the preceding information. Please sign the bottom portion of this form and return it to the front desk. Thank you.

- **X_______** Effective Jan 1, 2011. All patients, current or new, must have their health insurance card and an Identification card present at time of each visit. We will not accept your subscriber or I.D. number as proof of medical coverage. If you are unable to produce Insurance/Medical card, you will be responsible for all charges and fees incurred during your visit. We will not bill you for your visit at a later date. All charges are to be paid in full.
- **X_______** We do not offer any form of payment plan. Payment for all cosmetic procedures is due at time of service. NO EXCEPTIONS.
- **X_______** For the safety of patients receiving laser treatments there is absolutely no mobile phone use in the office.
- **X_______** I further understand that my failure to appear at a scheduled appointment without 24-hour cancellation notice is subject to a charge based on the length of your appointment scheduled.
- Do any of the following apply to you?
  - Has your name, address, or phone number changed?
  - Has your medical insurance provider changed?
  - Have you received a new insurance card since your last visit?
  - Has it been 2 or more years since you saw us last?
  - Have you signed a HIPAA privacy form?
- If you've answered yes to any of the questions listed above, please inform the front desk. All incorrect information is subject to a $25.00 re-filing fee.

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.
I have been informed that this practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.
I understand that this practice/clinic has the right to change their privacy practice and that I may obtain any revised notices at the practice/clinic.
I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).
I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Patient Signature:____ Date:_____/_____/_____

Patient Name: ______________________________ DOB: ____________

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THERAPEUTIC SKINCARE

PATIENT INTEREST QUESTIONNAIRE

Please select any procedures/issues that interest you (check all that apply):

Collagen
Skincare products
Microdermabrasion
Juvederm Ultra® or Ultra Plus®
Jessner's Peel
Acne
VI Peel®
Laser Resurfacing
Laser Treatments
Hair enhancement
Restylane® or Perlane®
Birthmarks
Age reversal recommendations

BOTOX® Cosmetic (Botulinum Toxin Type A)
Skin tightening
Liver/age spots
Sclerotherapy
Laser Hair Removal
Hair loss
Warts
Product information
Brown spots on the face, neck or chest
Scarring
Melasma
Skin cancer
Sweating
Stretchmarks
Facial Wrinkles

Chemical Peels (Glycolic)
Skincare advice
Smile lines
Leg veins
Cellulite reductions
Facial veins
Sun damage
Skin lifting
Sunscreen
Rosacea
Mineral Make-up
Prescription
Psoriasis
Over the counter products you've seen advertised
Other: ___________________

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

- When looking at my face in the mirror, I believe I look younger, the same as, or older then my true age.
  - ❑ Younger
  - ❑ True Age
  - ❑ Older
- When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.
  - ❑ Not concerned
  - ❑ Somewhat concerned
  - ❑ Very concerned

What is your current skincare regimen?

Morning	Evening
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________