David M. Amron, M.D.
120 S. Spalding Drive, Suite 315
Beverly Hills, CA

Welcome to our practice. It is our goal and privilege to provide you with the finest cosmetic and dermatologic care possible. We look forward to a successful and rewarding relationship with you.

- Payment is due in full for any minor (Botox, fillers, lasers, etc.) cosmetic procedures or products purchased on the date of service. For cosmetic surgical procedures such as liposuction, a deposit is collected upon scheduling and the remaining balance is due at the pre-op appointment.

- If we are billing your insurance company we must have a copy of your current insurance card at the time of service.

- For cosmetic patients, consultations are complimentary.

- For dermatology, appointments may either be billed to your insurance company or are on a cash pay basis

- For all patients, including cosmetic patients, please note that dermatology questions, diagnosis, and treatment will be billed to your insurance by Dr. Amron. If you do not have insurance, please ask what the fee will be for diagnosis and treatment of dermatological conditions such as acne, rashes, moles, etc.

- If you arrive more than 15 minutes late for an appointment we may either work you into the schedule that same day (which may involve a wait) or we may have to reschedule your appointment for a different day.

Please sign and date below to indicate your understanding.

Print Name:_____ Date:_____

Signature:_____

Thank you for your cooperation.

At Spalding Drive we are dedicated to providing our patients with the newest and most effective procedures and products to enhance the appearance of your skin, face, and body. Our patient care coordinator is available by request to answer all of your questions. Please choose from the following services.

Name ..... Phone No. .....

Please check

- ☐ Skin Rejuvenation
- ☐ Acne
- ☐ Laser Resurfacing for Wrinkles and Scars
- ☐ Rosacea
- ☐ Laser Treatment of Facial and Leg Broken Blood Vessels
- ☐ Diseases of the Skin
- ☐ Mole Removal
- ☐ Skin Cancer Surgery and Reconstruction
- ☐ MOHS Micrographic Surgery
- ☐ Scar and Keloid Treatments
- ☐ Dermabrasion
- ☐ Age Spots and Freckles
- ☐ Rashes, Eczema and Psoriasis
- ☐ Birthmarks
- ☐ Facial Blood Vessels
- ☐ Sclerotherapy of Leg Veins
- ☐ Chemical Peels
- ☐ Hair Loss Treatment
- ☐ Laser Hair Removal
- ☐ Customized Clinical Facials
- ☐ Professional Home Skin Care
- ☐ Microdermabrasion
- ☐ Photorejuvenation Of Face, Neck & Chest
- ☐ Corrective Procedure for Sweating of the Hands, Feet and Armpits

Health Care Referrals

As a service to our patients, we have compiled a group of doctors and other health care professionals that we place our trust in.

- ☐ Internal Medicine
- ☐ Cardiology
- ☐ Lasik Eye Surgery
- ☐ Cosmetic and Reconstructive Dentistry
- ☐ Obstetrics / Gynecology / Infertility
- ☐ Ophthalmology
- ☐ Nutritional and Weight Loss Counseling
- ☐ Anti-Aging Medicine
- ☐ Chiropractic Care

Please check

- ☐ "Mini Liposuction" and Liposuction Body Contouring
- ☐ "Anti-Gravity" Midfacelift
- ☐ "Mini-Facelift"
- ☐ "Mini-Midfacelift"
- ☐ Face and Neck Lift (Rhytidectomy)
- ☐ Endoscopic Brow and Forehead Lift
- ☐ Eyelid Surgery (Blepharoplasty)
- ☐ Hollow Eye Correction
- ☐ Lower Eyelid Fat Repositioning
- ☐ Surgery of the Nose (Rhinoplasty)
- ☐ Revision Rhinoplasty
- ☐ Snoring and Sinus Surgery
- ☐ Deviated Septum Correction
- ☐ Chin Augmentation
- ☐ Transumbilical Breast Augmentation
- ☐ Breast Augmentation, Lift and Reduction
- ☐ Tummy Tuck
- ☐ Buttock, Thigh and Arm Lifts
- ☐ Protruding Ear Correction (Otoplasty)
- ☐ Lip and Soft Tissue Augmentation
- ☐ Micrograph Hair Transplantation
- ☐ Scar Revision
- ☐ Botox®
- ☐ Collagen
- ☐ Migraine Treatment with Botox®
- ☐ Hand Rejuvenation
- ☐ Fat Transfers

Complete Image Advice

Update your appearance with professional advice from our in-house beauty and image consultant. Learn how you can look your best.

- ☐ Hair Styling
- ☐ Makeup Artistry
- ☐ Personal Training
- ☐ Cellulite Reduction
- ☐ Massage Therapy

www.spaldingplasticsurgery.com
120 South Spalding Drive | Suite 315 | Beverly Hills, CA 90212 | Ph. 310.275.2467 | Fax 310.275.6651

Spalding Drive Cosmetic Surgery & Dermatology, A Medical Corp.
120 S. Spalding Dr. Suite 315 Beverly Hills, CA 90212
(310) 275-2467 FAX (310) 275-6651

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____ Phone Number _____

City _____ State _____ Zip _____ Cell phone Number _____

Pharmacy Name _____ Pharmacy Phone Number _____

Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____ Email: _____

Please tell us how you learned about us: _____

Whom may we thank for referring you: _____

In case of an emergency who should be notified: _____ Phone: _____

Personal Physician _____ Physician's Phone _____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient _____ Phone _____

Address _____

PRIMARY INSURANCE

Subscriber Name _____ Relationship to Patient _____ Birth date _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by: _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Policy # _____ Group # _____ Subscriber # _____

SECONDARY INSURANCE

Subscriber Name _____ Relationship to Patient _____ Birth date _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by: _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Policy # _____ Group # _____ Subscriber # _____

ASSIGNMENT AND RELEASE

I authorize treatment of the individual named as Patient. I understand that Spalding Drive Cosmetic Surgery & Dermatology, A Medical Corp. will file with my primary insurance for services rendered and I authorize payment of medical insurance benefits to be made to my treating physician. I also understand that I am financially responsible for any services that are not covered under the terms of my policy.

I authorize Spalding Drive Cosmetic Surgery & Dermatology, A Medical Corp. to release or obtain any medical information related to its treatment of Patient. A photocopy of this authorization shall be considered as effective and valid as the original.

I fully understand and comply with this policy:

_____
Signature of Patient or Responsible Party Date

Dr. David Amron, M.D.
Spalding Drive Cosmetic Surgery Center & Dermatology, A Medical Corp.
120 S. Spalding Dr. Suite 315
Beverly Hills, CA 90212
(310) 275-2467

PATIENT HISTORY INFORMATION

WHAT IS THE NATURE OF TODAY'S VISIT? (Please List) _____

DURATION OF EACH PROBLEM? _____

LIST ANY TREATMENT FOR ABOVE PROBLEMS: _____

PRIOR DERMATOLOGIC CONDITIONS (Please List): _____

OTHER PAST AND PRESENT MEDICAL CONDITIONS: _____

PRIOR SURGERIES (Please Include Dates):

FAMILY HISTORY OF SKIN CANCER AND OTHER SKIN CONDITIONS:

CURRENT PRESCRIPTION AND/OR OVER-THE-COUNTER MEDICATIONS (Please List):

ANY ALLERGIES (Please List): _____

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COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want to know that all our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way the growing problem of improper discloser of PHI. As part of the plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of the fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support you full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request too refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Date:_____

Signature:_____

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Patient Questionnaire and HIPPAA Acknowledgment

Patient Name: _____ Date: _____

You may be contacted by Spalding Drive Cosmetic Surgery and Dermatology to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

May we contact you at home? ***Y/N*** *Tel. (___)* _____ *Ok to leave Voice mail* ***Y/N***
May we contact you at work? ***Y/N*** *Tel. (___)* _____ *Ok to leave Voice mail* ***Y/N***
May we contact you via cell phone? ***Y/N*** *Tel. (___)* _____ *Ok to leave Voice mail* ***Y/N***

Comments: _____

Can a message be left with our Center's name and what the call is in reference to? ***Yes/No***

Is there anyone we can leave a message with? ***Yes / No*** *(If yes, please list first and last names)*

_____ _____

_____ _____

Would you like to authorize an individual as you personal representative? This person would have the authority to schedule, confirm or change appointments only. Yes / No (If yes, please list first and last names)

_____ _____

_____ _____
Patient Signature Date