WELCOME TO THE OFFICE OF HEATHER J. ROBERTS, M.D., AMC

Our goal is to provide our patients with personalized expert skin care that meets and exceeds expectations. Please fill out these forms completely. The better we know your history, the better we can care for you.

Today's Date: _____ Referred By: _____

PATIENT'S INFORMATION:

Patient's Name: _____ _____ _____
Last *First* *Middle Initial*

Birth Date: _____ ☐ Male ☐ Female Home Phone #: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Billing Address if different than above: _____

_____

Pharmacy Name/Phone #: _____

Pediatrician's Name: _____ Phone #: _____

PARENTS' INFORMATION

Mother's Name: _____ Home Phone #: _____

E-Mail Address: _____ Cell Phone #: _____

Social Security #: _____ Driver's License #: _____

Home Address (If different from above): _____

Employer Name: _____

Father's Name: _____ Home Phone #: _____

E-Mail Address: _____ Cell Phone #: _____

Social Security #: _____ Driver's License #: _____

Home Address (if different from above): _____

Employer Name: _____

Nearest friend or relative residing at an address other than your own:

Name: _____ Relationship: _____ Phone #: _____

Address: _____

Other Family Members who are Current Patients: _____

TO RESPECT YOUR PRIVACY, PLEASE CHECK OFF THE PREFERRED NUMBERS AND/OR EMAIL ADDRESSES WE SHOULD USE TO LEAVE DETAILED PRIVATE INFORMATION FOR :

Appointment Reminders: ☐ Mom's Home ☐ Mom's Cell ☐ Mom's Email
☐ Dad's Home ☐ Dad's Cell ☐ Dad's Email ☐ Other _____

Lab/Biopsy Results: ☐ Mom's Home ☐ Mom's Cell ☐ Mom's Email
☐ Dad's Home ☐ Dad's Cell ☐ Dad's Email ☐ Other _____

PEDIATRIC HEALTH QUESTIONNAIRE — HEATHER J. ROBERTS, M.D., AMC

Patient Name: _____ Age: _____ Date: _____

HISTORY OF PAST ILLNESS:

Any Serious Illness ☐ Yes ☐ No If yes, please describe _____

HAVE YOU HAD ANY MAJOR SURGERY?

☐ Yes ☐ No Describe (Type and date): _____

ALLERGIES (Drugs, Chemicals, Food): _____

MEDICATIONS:

Prescriptions: _____

Over-the-Counter (Including vitamins&herbs): _____

Skin Care Products currently using: _____

GENERAL REVIEW:

Have you been in good health all your life? ☐ Yes ☐ No

Recent weight change? ☐ Yes ☐ No Gain/Loss ____

SKIN:

Acne	☐ Yes	☐ No
Abnormal pigmentation or loss of pigment	☐ Yes	☐ No
Sensitive skin (gets red or irritated easily)	☐ Yes	☐ No
History of scars or keloids	☐ Yes	☐ No
Hives, eczema or itching	☐ Yes	☐ No
Do you wear sunscreen everyday	☐ Yes	☐ No
Blistering sunburns	☐ Yes	☐ No
Warts	☐ Yes	☐ No

CARDIOVASCULAR (Heart & Blood Vessels):

Heart trouble	☐ Yes	☐ No
Do you require Antibiotics for dental work	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No

Other _____

GYNECOLOGICAL:

Do you get monthly periods	☐ Yes	☐ No
Date of your last period _____		
Birth control pill or hormone therapy	☐ Yes	☐ No
Name of birth control pill _____		

HEAD, EYES, EARS, NOSE OR THROAT:

Herpes Simplex or Cold Sores	☐ Yes	☐ No
Chronic sinus trouble	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No

Other _____

BLOOD/LYMPHATIC:

Blood disease or anemia, transfusions	☐ Yes	☐ No
Immune disorders (HIV or AIDS)	☐ Yes	☐ No
Any bleeding problems	☐ Yes	☐ No

ENDOCRINE (Glands):

Thyroid disease or goiter	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No

RESPIRATORY: Asthma or wheezing ☐ Yes ☐ No

PSYCHIATRIC:

Depression	☐ Yes	☐ No
Anxiety attacks	☐ Yes	☐ No

Other _____

SOCIAL HISTORY: Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

FAMILY HISTORY: (Check the following medical conditions that have occurred in your family)

	Mother	Father	Other Blood Relative		Mother	Father	Other Blood Relative
Asthma	☐	☐	☐	Psoriasis	☐	☐	☐
Hay Fever	☐	☐	☐	Skin Cancer(Non Melanoma)	☐	☐	☐
Eczema	☐	☐	☐	Malignant Melanoma	☐	☐	☐
Severe Acne	☐	☐	☐	Cancer	☐	☐	☐

ANY OTHER SKIN CONDITIONS THAT RUN IN YOUR FAMILY? ☐ Yes ☐ No

If yes, please explain _____

*Signature of Patient/Responsible party _____ (Required)

Date: _____

*If completing on line, please refer to the "digital signature" policy listed above.

Heather J. Roberts, M.D.
Diplomate, American Board of Dermatology

Christine Choi Kim, M.D.
Diplomate, American Board of Dermatology

Heather J. Roberts, M.D., A Medical Corporation
11500 W. Olympic Blvd., Suite 480
Los Angeles, CA 90064
310-477-4727

Financial Policy

Our office is not contracted with any insurance companies or Medicare. Full payment for all services rendered is expected at the time of your visit. At each visit we will provide a copy of your properly coded superbill. Please attach this superbill to your claim form (available on your insurance company's website) to submit for reimbursement directly to you. If you have any questions on how to access a claim form from your insurance, please contact your insurance company directly or call Patricia at our office.

If at any time you have questions or concerns regarding the cost of a procedure, insurance submissions or claim denials, our staff is here to assist you.

Please note you will be reimbursed by your insurance under "out of network" benefits and in accordance with your plan's allowables and deductibles. As each insurance plan has its own "rules" we cannot predict how much your plan will pay. If you want to contact your insurance company before any procedures or appointments in our office, we can give you the billing codes in advance (if we know what is being treated) so you can get an idea on the reimbursement.

RELEASE OF RECORDS: I authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case to process any past, present, and/or future claims. I understand this authorization can be withdrawn upon my request at any time.

For your convenience in paying, this office will accept your ATM/Debit card, Master Card, Visa, American Express and cash. For identity protection, we will need a copy of your driver's license at your first visit.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND AGREE TO ITS TERMS REGARDLESS OF MY INSURANCE STATUS.

I KNOW THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.

I certify that the information that I have provided is true and correct to the best of my knowledge. I will notify the office of Heather J. Roberts, M.D., AMC of any changes in my personal contact information.

I have read and agree to the above.

Patient Signature_____ Date_____

Legal Guardian Signature (if patient is a minor)_____ Date_____

Witness Signature _____ Date_____

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Cancellation Policy

We value the choice you have made in selecting our practitioners to take care of your skin health.

Our mission is to provide the highest quality, thorough and personalized dermatology care to all our patients. When scheduling, we try our best to accommodate your needs in a timely manner.

We understand conflicts may arise that require changing a previously scheduled appointment; however, we kindly request you cancel with at least 24 hours prior notification. Patients who cancel without 24 hours advance notice (last minute cancellations) or who simply do not show up (no shows) cause significant scheduling challenges in our office. We keep an active waiting list for patients requesting sooner appointments. Your courtesy in abiding by our cancellation policy allows us to better accommodate both your future and other patient's scheduling needs. We appreciate your understanding and consideration in this matter.

Failure to cancel an appointment within 24 hours prior to your scheduled time or not showing up for your appointment will result in a $250 fee for all medical visits OR 50% of the current fee for cosmetic and surgery appointments payable prior to scheduling any future visits.

As a holistic medical and cosmetic Dermatology practice, we believe in personalized care. As such, our patients often request appointments to accommodate multiple procedures, treatments, and medical concerns on the same day. While we are happy to offer these **"extended time" appointments**, it does create scheduling challenges when patients "No Show" or cancel with less than 24 hours' notice. **We appreciate your cooperation in paying a $750 deposit at the time of scheduling for these types of appointments. Failure to cancel an "extended time" appointment with at least 24 hours advance notice or not showing up will result in a cancellation fee equal to the entire pre-paid $750 deposit without exception.**

Repeated late cancellation or no-show appointments will result in your being discharged from our practice as we believe mutual respect is the cornerstone of a healthy, long-term doctor-patient relationship.

We send multiple appointment reminders via e-mail, text and if needed, phone calls in advance of all appointments. If you do not respond to these reminders, our cancellation policy will still remain in effect.

No future appointments will be scheduled, nor records transferred without settling up payment of any outstanding cancellation fees.

I have read and fully understand the above policy and agree to its terms.

Patient Signature _____
Legal Guardian Signature (if patient is a minor) _____
Relationship to patient_____ Date_____

Witness_____ Date_____

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I am a patient of Heather J. Roberts, MD and/or Christine C. Kim, MD.

I hereby acknowledge receipt of Heather J. Roberts, MD, AMC's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name].

I hereby acknowledge receipt of Heather J. Roberts, MD, AMC's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____