



Peyman Ghasri, M.D. F.A.A.D.

Castle Dermatology Institute
5363 Balboa Blvd., Suite 333
Encino, CA 91316
(818) 501-3376

Dear valued patient;

Welcome to my practice.

Thank you for choosing Castle Dermatology Institute where the highest level of patient care is our utmost priority.

Please complete the attached forms and all the requested information.

- Patient Information**
- Medical History**
- Privacy Policy**
- Assignment of Rights and Benefits**
- Cosmetic Questionnaire**
- Arbitration Agreement**

Please remember to bring your insurance cards and the ID of the subscriber if it is not on the card.

I realize that your time is valuable, and I make every effort to see you at your appointment time.

Thank you for choosing Castle Dermatology Institute again. I look forward to serving your dermatologic needs and a continued relationship with you and your family.

Sincerely,

A handwritten signature in black ink, appearing to read "Peyman Ghasri". The signature is fluid and cursive, written in a professional style.

Peyman Ghasri, M.D., F.A.A.D.

PATIENT INFORMATION

DATE ___/___/___
M DAY YR

NAME: LAST: _____ FIRST: _____ MI _____

BIRTH DATE _____ AGE _____ SS# _____

ADDRESS _____ APT _____ CITY _____

STATE _____ ZIP _____ SEX (M) (F) MARITAL STATUS (S) (M) (W)

OCCUPATION _____ EMPLOYER _____

EMAIL _____ HOME PHONE _____

WORK PHONE _____ CELLULAR _____

REFERRED BY _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CARRIER _____ PHONE _____

CLAIMS ADDRESS _____ CITY _____ STATE _____ ZIP _____

POLICYHOLDER (NAME ON CARD) _____

ID# _____ GROUP # _____

IF YOU ARE **NOT** THE POLICYHOLDER, PLEASE PROVIDE THE FOLLOWING:

POLICYHOLDER'S DATE OF BIRTH _____

POLICYHOLDER'S SSN# _____

PATIENT'S RELATIONSHIP TO POLICYHOLDER _____

PATIENTS WHO ARE MINORS WHO ARE PRESENT WITHOUT A GUARDIAN

IF YOU ARE A MINOR, THE INSTITUTE REQUIRES WRITTEN AUTHORIZATION FROM A LEGAL GUARDIAN THAT WE MAY CONDUCT A MEDICAL EXAM AND / OR TREATMENT WITHOUT THE PRESENCE OF A LEGAL GUARDIAN.

TO BE COMPLETED BY LEGAL GUARDIAN & FAXED TO INSTITUTE AT (818) 501-3337

I AUTHORIZE _____ TO BE SEEN WITHOUT A LEGAL GUARDIAN

PRESENT: SIGNATURE _____ RELATIONSHIP _____

DAYTIME TELEPHONE _____ DATE _____

May we leave confidential medical messages on your voice mail? Yes ___ No ___

Please note preferred phone number: (___) _____

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MEDICAL HISTORY

Patient _____

Date _____

Reason for today's visit: _____

Are you allergic to any medications? Yes No If yes, which?

1. _____ 2. _____ 3. _____

List all medications you are currently taking (include Rx, herbal or over the counter, aspirin, etc.):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Do you have now or have ever had diseases or conditions of: (Please check Yes or No)

	Yes	No		Yes	No
Lungs:			Other Systemic:		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney:		
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach:		
Vascular:			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Yellow		
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy		
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

Do you drink alcohol? Yes No If yes, _____ drinks per day

Do you use IV drugs? Yes No If yes, what? _____ How much? _____

Have you had or have been exposed to HIV (AIDS)? _____

Have you ever had dental anesthesia? Yes No Any bad reaction? _____ When? _____

Skin:

When you are exposed to sun do you: Tan Only Tan and Burn Burn

Have you ever had skin cancer? Yes No If so, what type?

Has anyone in your family had skin cancer? Yes No If so, who?

Do you have a history of any specific skin disease? Yes No

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

A. Do you smoke?

B. Do you bleed easily?

C. (Women) Are you pregnant?

D. Do you have artificial joints?

E. What is your occupation? _____ Hobbies: _____

Patients Signature: _____

PRIVACY POLICY

PATIENT ACKNOWLEDGMENT AND CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your right under the law. You have the right to review our Notice before signing this Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge that you have received a copy of CDI's Privacy Policy. By signing, you also consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- * Protected health information may be disclosed or used for treatment, payment, or health care operations
- * Castle Dermatology Institute has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- * Castle Dermatology Institute reserves the right to change the Notice of Privacy Practices
- * The patient has the right to restrict the uses of their information but Castle Dermatology Institute does not have to agree to those restrictions
- * The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- * Castle Dermatology Institute may condition receipt of treatment upon the execution of this Consent.

This Acknowledgment/ Consent was signed by:

Printed Name-Patient or Representative

Signature

____/____/____
Date

Relationship to Patient
(if other than patient):

Witness:

Printed Name-Castle Dermatology Institute Rep.

Signature

____/____/____
Date

PATIENT RESPONSIBILITY FOR LATE CANCELLATION OF APPOINTMENT

I understand that it is my responsibility to inform the office no later than 24 hours prior to my scheduled appointment if I am unable to keep the appointment. If I cancel my appointment AFTER the 24 hour time period or "NO SHOW" I understand I will be charged a fee according to the length of time allotted for my appointment. Regular office visits will be charged a \$25 fee. Mole or Skin Cancer Excision appointments will be charged a \$50 fee. Moh's Micrographic Surgery (Skin Cancer) will be charged \$300 due to the cost of the lab technician that is paid on a per case basis .

If I have any questions regarding these fees I will ask for further explanation BEFORE my next appointment.

PATIENT

SIGNATURE _____ DATE _____

ASSIGNMENT OF RIGHTS AND BENEFITS

Patient's Name (or responsible party for a minor) _____

I hereby assign all rights and benefits under my contract with my insurance company to, Peyman Ghasri MD, A Professional Corporation for the purposes of determining the details of the benefits of my policy and obtaining payment for services given.

The assignment further permits Dr. Ghasri to obtain from my insurance all information necessary for the determination of benefits allowed under the contract and permits the direct disclosure to Dr. Ghasri of all information including benefits provided, limits and exclusions of benefits and reasons for denial of benefits or reduction in charges for services rendered.

The assignment shall allow Dr. Ghasri to take all action necessary to obtain the benefits I have, in good faith, been promised by my insurance. All benefits are to be paid directly to Dr. Ghasri. A photocopy of this assignment shall be considered as effective and valid as the original.

I further authorize Dr. Ghasri to initiate a complaint to the Insurance Commissioner's office for any reason on my behalf.

I understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary or cosmetic. I agree to be responsible for payment of all such services rendered to me or my dependents.

I also understand that my insurance policy is a contract between my insurance company and I. If my insurance company does not pay my claim within 30 days after it is received, I agree to remit payment to Dr. Ghasri within 2 weeks of receiving the bill, and contact my insurance company regarding this settlement. Dr. Ghasri and his staff will assist me in processing my claim; however, I am ultimately responsible for payment of my account.

This is a direct assignment of my rights and benefits under this policy.

Policy Holder/Insured Name _____

Patient Name

Date

Patient Signature

AESTHETIC INTEREST QUESTIONNAIRE

- Please indicate areas of interest/Concern:

Complimentary Cosmetic Consultation

Acne treatment

Wrinkle treatment

Crows feet

Laugh lines / vertical lines

Drooping eyebrows

Undereye circles

Facial and/or Leg Veins

Liver Spots/ Age Spots

Hair removal

Keloids / Scars

Facial moles / growths

Skin care advice

Skin care products

BOTOX ® Cosmetic

Restylane / Juvederm Fillers

Radiesse facial augmentation

Restoring prominent chin

Enhancing cheekbones

Skin rejuvenation

Thin lips

Glycolic peels/ acne peels

If others, please specify: