Pacific Dermatology & Cosmetic Laser Center

DR DOUGLAS M KEEL
OFFICE 858.535.1400
FAX 858.535.1900

Welcome to Pacific Dermatology

We want to thank you for choosing Pacific Dermatology for all your medical, cosmetic, and skincare needs.

First, we need a photo of the front and back of your current valid medical insurance card. Please email these photos to info@pacificdermatologycenter.com as soon as possible. It is a good idea to call your insurance company to make sure Dr. Keel is a provider within your plan.

We will email a link to you which will allow you to access our patient portal to complete your registration. Once on the patient portal, go to the "My Health" tab to update/complete relevant information such as medications and past medical history. You must complete this before your appointment.

We are excited to offer our patients tele-dermatology. Tele-dermatology is great for consultations, acne, rashes, skin lesions, prescription refills, and many other skin conditions. If you would like a secure tele-dermatology visit using phone and video from the comfort of your home, please contact our office at (858)535-1400. If you have already made a tele-dermatology appointment, we will email you a separate link to download and access the "Pocket Patient" app.

Your user name for both our patient portal and the "Pocket Patient" app will be your email, and you will be prompted to set a password. Once you have established a password, it will be the same for your patient portal and the "Pocket Patient" tele- dermatology app.

You can always access your patient portal at **pacificderm.ema.md** and select **patient login.**

If you ever have any difficulties with the technology, please call us at (858) 535-1400 and we are happy to help you.

We look forward to seeing you!

In good health,

Douglas Keel, DO
Diplomate, American Board of Dermatology
Fellow, American Academy of Dermatology
Fellow, American Society for Dermatologic Surgery

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Please complete these 3 forms and bring with you to your visit.

Name Last_____First_____Middle Initial_____

Title (please circle one) Mr Mrs Ms Miss Dr Jr Sr I II

Sex (please circle one) Male Female Other

Address Apt, Suite _____

Address _____

City _____ **State** _____ **Zip**_____

Date of Birth _____

Cell Phone _____ **Home**_____**Work**_____

E-Mail Address_____
(This is required for tele-dermatology, patient portal, and all of our special deals!)

Preferred pharmacy_____**Pharm city/Zip Code**_____

Financial Policy

Welcome to our office. We appreciate the opportunity to provide you with excellent service and specialized patient care. In order to maintain our high standards, we believe it is important that we communicate our policies to you up front. Should you have any questions, our office staff and Dr. Keel are happy to help you.

1. Payment is due at the time of service. We accept cash, Visa, MasterCard, and AMEX. Insurance cards and proof of identity are required to be presented before every visit.

2. **In-Network Services:** We are contracted with many insurance companies and other health plans to accept payment for services. At this time, we provide in-network services for Aetna PPO, Anthem Blue Cross PPO, Blue Shield PPO, United Healthcare PPO, Healthnet PPO, Cigna PPO and Medicare, among others. You are required to pay any co-payments on the date of service. **Please be advised that it is your responsibility to ensure we are In-Network at the time of your visit. You will be responsible for any remaining balances after your insurance processes the claim. Balances may be a result of a deductible that has not been met, co-insurance or non-covered items. We do not take any HMO's without a referral and authorization for treatment.**

3. **Out-of-Network Services:** If you are insured by a PPO plan that we do not have a prior arrangement with, the fees will be processed as out-of-network. We will send the claim for you, but many times you will pay higher than in-network fees for our services and some services may not be covered. **Please be advised that you are ultimately responsible for all charges for services rendered. HMO insurance is not accepted without a referral and will be treated as Self-Pay.**

4. Not all insurance plans cover all services and fees. In the event your insurance plan determines a service to be "cosmetic" or "not covered" or excluded under your plan for any reason, **you will be responsible for the complete charge**. Payment is due upon receipt of a statement from our office. All cosmetic services are to be paid in full at the time of service.

5. Upon receipt of payment from your insurance company, we will adjust our fees and bill you for the remaining balance. This amount is often your unmet deductible or co-insurance. If the amount due is over 90 days, a final notice for payment will be sent to you. If payment is not received within 30 days of the final notice, a collection agency will be employed to collect the balance due. This may result in additional fees and adversely affect your credit. A $50.00 fee will be charged for any returned checks.

6. Tele-dermatology visits will be billed to your insurance on file. Co-pays will be paid online prior to your appointment. For self-pay patients, we require full payment when your appointment is scheduled.

I hereby assign payment directly to Douglas M. Keel, D.O., Inc. for all benefits otherwise payable to me for services rendered. **I understand that I am financially responsible for all the charges whether or not they are paid by insurance.** I have read and understand the practice's financial policy and I agree to be bound by its terms. I am aware that services are provided exclusively by Douglas M. Keel, D.O., Inc., doing business as Pacific Dermatology & Cosmetic Laser Center. I hereby authorize the doctor to release any information necessary to secure the payment of benefits. I also understand that it is my responsibility to make sure that the bill is paid in a reasonable time (within 30 days).

X_____ _____ _____

Signature of Patient (or guardian if under 18) | **Relationship to Patient (if signed by guardian)** | **Date**

X_____

Please print the name of the patient

HIPAA Consent

I hereby give my consent for Pacific Dermatology & Cosmetic Laser Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Pacific Dermatology & Cosmetic Laser Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pacific Dermatology & Cosmetic Laser Center reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pacific Dermatology & Cosmetic Laser Center's Privacy Officer, Heather Kenney at 8899 University Center Lane STE 150 San Diego, CA 92122.

With this consent, Pacific Dermatology & Cosmetic Laser Center may call my home or other alternative location and leave a message on voice mail or in person in reference to any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Pacific Dermatology & Cosmetic Laser Center may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Pacific Dermatology & Cosmetic Laser Center may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pacific Dermatology & Cosmetic Laser Center restrict how it discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions.

By signing this form, I am consenting to Pacific Dermatology & Cosmetic Laser Center's use and disclosure of my PHI to carry out TPO.

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, or later revoke it, Pacific Dermatology & Cosmetic Laser Center may decline to provide treatment to me.

X _____ _____ _____

Signature of Patient (or guardian if under 18) | **Relationship to Patient (if signed by guardian)** | **Date**

X _____

Please print the name of the patient