



Natural Image OC

PATIENT REGISTRATION

General information

Name  
 LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
 SEX  M  F DRIVERS LICENSE # \_\_\_\_\_ STATE \_\_\_\_\_  
 MARITAL STATUS:  Married  Single  Divorced  Widowed  Domestic Partner  
 PARENT/GUARDIAN NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 SOCIAL SECURITY NUMBER (Parent/Guardian) \_\_\_\_\_ DOB (Parent/Guardian) \_\_\_\_\_  
 Language Preference \_\_\_\_\_ Ethnicity \_\_\_\_\_ Race \_\_\_\_\_

Addresses

Home Address  
 STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_  
 WOULD YOU LIKE TO RECEIVE TEXT UPDATES REGARDING YOUR APPOINTMENT?  Yes  No  
 EMAIL ADDRESS \_\_\_\_\_

EMPLOYER \_\_\_\_\_  
 OCCUPATION \_\_\_\_\_  
 WORK ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
 WORK PHONE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_  
 IN CASE OF EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

Primary Insurance

NAME OF PRIMARY INS \_\_\_\_\_ PHONE \_\_\_\_\_  
 ID/POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
 SUBSCRIBER/INSURED \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ SEX \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
 EMPLOYER NAME \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_

Secondary Insurance

NAME OF SECONDARY INS \_\_\_\_\_ PHONE \_\_\_\_\_  
 ID/POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
 SUBSCRIBER/INSURED \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ SEX \_\_\_\_\_  
 DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_  
 EMPLOYER NAME \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_

I, the undersigned, assign directly to **Natural Image OC, Lenore M. Sikorski, M.D. INC.**, all medical benefits if any, otherwise payable to me for services rendered. I understand that I will be required to present my health insurance card and drivers license to ensure coverage and identity. I hereby authorize the doctor to release all information necessary to secure payment of benefits.

Signature \_\_\_\_\_

Date \_\_\_\_\_



Natural Image OC

**PATIENT QUESTIONNAIRE**  
(Please Print)

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Profession: \_\_\_\_\_

**How did you hear about our practice?**

- Physician Referral \_\_\_\_\_
- Personal Referral \_\_\_\_\_
- Orange County Register Newspaper
- OC Magazine      Other Magazine \_\_\_\_\_
- Phonebook

Internet Search:

- Google       Bing       Realself.com       Facebook
- Yahoo       Ratemds.com       Locateadoc.com

Other Internet Search: \_\_\_\_\_

**Our practice offers a full range of skin care services. Please mark the procedures that interest you:**

- Skin Check                       Facelifts                       Hair Removal
- Removing Brown Spots       Dermal Fillers               Liposuction
- Skin Tightening               Vein Treatment               Acne Treatment
- Skin Tag/Mole Removal       Laser Skin Resurfacing
- Chemical Peels               Eyelid Surgery

Other concerns with your facial/body appearance: \_\_\_\_\_

\_\_\_\_\_

**What products are you using presently and if known, what is the brand name?** \_\_\_\_\_

\_\_\_\_\_

**Are your current skin care products giving you the results you want?**     Yes     No  
**If no, would you like us to assist you in choosing a skin care program specific to your needs?**  
 Yes     No

**Would you be interested in attending a seminar in our office about:**

- Surgical Solutions to Aging or Appearance Improvement
- Nonsurgical Solutions to Appearance Improvement i.e., Cosmetic Lasers, Botox, and/or Dermal Fillers
- Skin Cancer and Skin Problems



# Natural Image OC

## HEALTH HISTORY CHECKLIST

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

### Medications/Alternative medications (Vitamins, Herbs, etc.)

Please list any medications you are currently taking and the correlating diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Allergies

Aspirin  Other allergies \_\_\_\_\_  
 Barbiturates (sleeping pills) \_\_\_\_\_  
 Codeine \_\_\_\_\_  
 Iodine \_\_\_\_\_  
 Local anesthesia \_\_\_\_\_  
 Penicillin \_\_\_\_\_  
 Sulfa \_\_\_\_\_  
 Latex \_\_\_\_\_

Do you smoke?  Yes  No How many per day? \_\_\_\_\_

Have you ever taken any of the group of drug collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

### Please mark on Yes or No to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen feet or ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Nervous problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No		

### Women

Are you pregnant?  Yes  No Due date: \_\_\_\_\_ Are you nursing?  Yes  No  
Taking birth control pills?  Yes  No

### Skin history

Do you get a lot of sun exposure, or have you had a lot of sun exposure in the past?  Yes  No  
Have you ever had skin cancer?  Yes  No  
Do any family members have a history of skin cancer?  Yes  No  
Do any family members have a history of melanoma?  Yes  No  
Have you had x-ray treatment? (acne, thyroid, etc.)?  Yes  No  
When you are exposed to sunlight do you  Burn  Burn then tan  Tan only



## Natural Image OC

### NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of this practice, Natural Image OC/Lenore M. Sikorski, M. D., Inc., may be used and disclosed, and how to access your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

The following circumstances may require us to use or disclose your health information:

1. **To provide treatment:** We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, technician, nurse, and business office staff. In pathology laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to authorize health care providers treating patients even when the provider requesting the results did not originally order the tests.
2. **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you received in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.
3. **To conduct health care operations:** Your health information may be used during performance evaluations of our staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.
4. **Communications:** Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact us to make an appointment. These communications may include postcards, letters, and telephone reminders. We may share your health information with those you tell us will be helping you with your home treatment, medications, or payment. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home, rather than work. We will try to accommodate reasonable requests.
5. **Required by law:** We may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collect information, when required to do so by a law enforcement official, lawsuits and similar proceeding in response to a court or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public, for Worker's Compensation and similar programs.

Our patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultation and correspondence are reviewed by the physician prior to being filed in the medical records. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information.

You are entitled to receive a copy of this Notice of Privacy Practices.

I \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, health care operations and laboratory testing.

Signature: \_\_\_\_\_  
(Parent/guardian if patient is a minor)

Date: \_\_\_\_\_



## Natural Image OC

### **FINANCIAL POLICY AND AGREEMENT**

Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. Should you be a cash patient, we may not ask for full payment at the time of service, although you will remain responsible for the full payment of all fees for services provided. If you have health insurance, we bill your insurance company directly, and you will be responsible for co-payments, coinsurance, deductible, and/or non-covered amounts. For your convenience, our office accepts personal checks, credit cards, and cash. Please read the following carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, and disallow procedure codes, and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" charges - the amount they are willing to cover. The insurance company reduces the fees according to your individual policy's which applies amounts to your annual benefits (including co-payments, coinsurance, or deductible).

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes. Your insurance carrier will process the claim and determine reimbursement rates. Claims may also be denied depending on your benefits. By contracting with your insurance company, we are required to write-off the difference between the billed amount and the contracted amount ("reasonable and customary"). You will be billed for co-payments, coinsurance, or deductible. If we do not have a contract with your insurance carrier, you are responsible for the amount in full.

We are required by all insurance carriers to collect from patients co-payments, coinsurance, or deductible amounts. These fees can be reduced only in those cases where true financial hardship can be demonstrated. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of Non-Sufficient Funds or your account is turned over to Collections, you will responsible for all related costs.

I have read and understand Natural Image OC/Lenore M. Sikorski, M. D., Inc, financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Natural Image OC/Lenore M. Sikorski, M. D., Inc.

I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize Natural Image OC/Lenore M. Sikorski, M. D., Inc., to release all information necessary to secure payment of benefits.

Patient Legal Name (please print clearly): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/guardian if patient is a minor)



Natural Image OC

**PATIENT/PHYSICIAN ARBITRATION AGREEMENT**

1) It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, this arbitration agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

2) ALL CLAIMS MUST BE ARBITRATED. I understand that all claims for damages arising from medical services rendered by Natural Image, and/or associate or substitute physicians, nurses or employees must be arbitrated. This includes any claim of a spouse, heir, child (born or unborn), or other successor in interest to any such claim.

3) ARBITRATION PANEL. Within 30 days of a demand to arbitrate a dispute, which must be made in writing, the parties shall agree of three medical arbitrators. Each party will bear the costs for their own legal counsel, and other expenses incurred for their own benefit, as well as their pro rata share of arbitration expenses.

4) APPLICABLE LAW. I agree that the California Code of Civil Procedure relating to arbitration shall apply without any exception.

5) REVOCATION OF THE AGREEMENT. This agreement may be revoked and canceled by written notice delivered to Natural Image within 30 days of the signing of this agreement. If notice of revocation of this agreement is not received within 30 days of its signing, the right to cancel the agreement is forever waived.

6) RETROACTIVE EFFECT. If the signing party intends this agreement to cover all services rendered before the date of the signing of this agreement (including, but not limited to, prior consultations or treatment), the signing party must initial here:

7) ACKNOWLEDGEMENT. By signing this agreement, the signing party acknowledges he/she discussed to his/her satisfaction any questions he/she may have had regarding the arbitration agreement with Natural Image, an associate physician, or authorized legal representative of Natural Image.

8) If any provision of this arbitration agreement should be held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OF COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/guardian if patient is a minor)

If signed by someone other than the patient, indicate relationship: \_\_\_\_\_

Physician's agreement to arbitrate: In consideration of the foregoing execution of the Patient/Physician Arbitration Agreement, Natural Image OC/Lenore M. Sikorski M.D., Inc., and Staff likewise agree to be bound by the terms set forth in agreement.