KARIMIPOUR DERMATOLOGY & AESTHETIC SURGERY
DARIUS KARIMIPOUR M.D., P.C.
43700 WOODWARD AVENUE SUITE 110
BLOOMFIELD HILLS, MI 48302
Phone: 248-332-0103 | Fax: 248-332-1070

Patient Health History Form

Today's date: _____ NAME: _____
Your age: _____ Date of Birth: _____
Occupation: _____
Marital Status: _____ Sex: M / F Visit No. _____
Race and Ethnic Group: _____
Home phone #: _____
Work or other phone #: _____

Dr. who sent you here: _____ Tel: _____ City: _____

Your **Family** Dr.: _____ Tel: _____ City: _____

Your **Heart** Dr.: _____ Tel: _____ City: _____

Other Dr.: _____ Tel: _____ City: _____

Pharmacy: _____ Tel: _____ City: _____

Have you had a skin cancer treated by Mohs surgery before? NO / YES If yes, when? _____

Regarding the spot(s) that you were sent to us for:

1st spot: Where is it on your body? _____
How long have you had this spot? _____
Has it been (circle) Itching? Painful? Bleeding? Growing? Crusting? Other: _____
Not counting the biopsy, has it been treated before? NO / YES if yes, please explain how: _____
_____

2nd spot: Where is it on your body? _____
How long have you had this spot? _____
Has it been (circle) Itching? Painful? Bleeding? Growing? Crusting? Other: _____
Not counting the biopsy, has it been treated before? NO / YES if yes, please explain how: _____
_____

Please list all medications including prescriptions, over the counter (vitamins/aspirin/etc), supplements-herbs you take regularly.

MEDICATION/DOSE	FREQUENCY	MEDICATION/DOSE	FREQUENCY	MEDICATION/DOSE	FREQUENCY

Are you allergic to any medications? (Mark "X")

_____ NO, I have no known drug allergies.
_____ YES, I am allergic to the following medicines. (Please, explain below)

1. _____ Reaction _____
2. _____ Reaction _____

- Do you use sunscreen on a daily basis? NO/YES If YES, what SPF? _____
- Do you use a tanning bed? NO/YES
- Have you had 5 or more sunburns in your lifetime? NO / YES
- Have you had radiation treatment to your skin? NO / YES
  If yes, where on your body and for what? _____
- Do you smoke? Please circle one of the following : Cigarettes Marijuana No
- Consume any alcohol? If yes, please specify. _____

Please check either N for no or Y for yes in each row:

IMPORTANT MEDICAL HISTORY	N	Y	CONTINUED	N	Y
History of Heart attack WHEN? _____			HIV / AIDS		
Angina/Chest Pain WHEN? _____			Hepatitis / liver problems		
Arrhythmia (irregular heartbeat)			Diabetes		
Pacemaker/Automatic Implanted Cardiac Device			High blood pressure		
Defibrillator			Auto immune disease(Lupus, other)		
Murmur			Hypo or Hyperthyroidism (circle)		
Artificial heart valve			Bleeding problems (such as clotting etc.)		
Require antibiotics before procedures, Please explain			Arthritis		
			High Cholesterol		
Other heart problems, Please explain			Hearing Loss		
Cancer (other) / Type:			Vision Loss? Please specify.		
Organ Transplant / Which organ and date:			Gastrointestinal problems		
Seizures. When? _____			Skin disorders?		
Lung problems, Asthma, Emphysema, Sleep Apnea? (Please Circle one) or explain:_____			Artificial joints/pins. Where and When?		
Do you need supplemental O2 or CPAP?			Psychiatric disorder		
Stroke/Mini-stroke (TIA) When? _____ (Please circle one)			Pregnant or breast feeding Due date:		

If you have had a major illness or major surgery in the past 5 years, please explain: **Month/Day /Year**

_____ _____

_____ _____

Do you have a family history of Cancer? YES___ NO___

If YES, which family member and which type of cancer? Please only list first degree relatives (Parents, Siblings, Grandparents, Children, Grandchildren, Aunt, Uncle, Niece, Nephew).

Family member	Type of cancer

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REGISTRATION FORM

Today's date:	Family Dr.	Local Pharmacy:

PATIENT INFORMATION

Patient's last name:	First Name:	Middle:

Social Security #	Email (for Portal Access):	Birth Date:	Age:	Sex: ☐ M ☐ F

Address:	Apt #	Home Phone #

City:	State:	ZIP Code:	Cell Phone #

Preferred Contact Method for Appointment Reminders Please Circle Cell Home Email Text	May we leave a voicemail if contacted by phone? Please Circle: Yes or No	Work Phone #

*********How were you referred to us? **********	☐ Dr. or Hospital	☐ Friend/Family	☐ Insurance Plan	☐ Other

Other family members seen here:	
Occupation:	Employer:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone #

Is this patient covered by insurance?	☐ Yes	☐ No

Insurance Name:	☐ Medicare	☐ BCBS	☐ Medicaid	☐ HAP	☐ Cofinity/PPOM	☐ Other _____

Contract/Policy #:	Group #:

Subscriber's name:	Subscriber's S.S. #	Birth date:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy #	Group #

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #:	Work phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Darius J. Karimipour MD PC or insurance company to release any information required to process my claims.

Patient or Guardian Signature:	Date:

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HIPAA

I am a patient of Darius J. Karimipour, M.D., P.C.

I hereby acknowledge receipt of Darius J. Karimipour, M.D., P.C.'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 Darius J. Karimipour, M.D., P.C.'s Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

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PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of Darius J. Karimipour, M.D., P.C. not to release confidential medical information regarding your treatment to family members or friends, *except* for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. **If you do not want any of your medical information provided to a family member, please mark DECLINE.**
By checking YES, you authorize the following people to receive information regarding your treatment or care. You are entitled to receive a copy of this form at any time, and can request a new copy if any changes are made.

***If you wish to make changes to this form in the future please confirm this in writing, or call our staff.*

Spouse: _____ _____ YES _____ DECLINE

Parent: _____ _____ YES _____ DECLINE
Other:_____ _____ YES _____ DECLINE

_____ _____ YES _____ DECLINE

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us by phone.

Best Contact Method:_____

PATIENT NAME (please print) _____

PATIENT Signature: _____ Date: _____
Legal Guardian Signature:_____ Date: _____

FOR OFFICE USE ONLY
Changes to above that were authorized by patient via phone:

Change Made	Date	Staff Initials
_____	_____	_____

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Pharmacy-Fill Consent Acknowledgement

I, _____, give Darius J Karimipour MD, PC permission to electronically import my pharmacy-fill history through the Surescripts pharmacy network. This permission will remain in force until I contact Darius J Karimipour MD, PC in writing to remove it. I understand that giving Darius J Karimipour MD, PC access to this information will assist in keeping my medical record accurate.

Signature/Date

Witness

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Patient Responsibility Policy

Thank you for choosing Darius J. Karimipour, M.D., P.C. (dba Karimipour Dermatology and Aesthetic Surgery). Our primary mission is to deliver the best and most comprehensive care available. An important part of our mission is to help make the cost of optimal care as easy and manageable for our patients as possible by offering the following payment options.

You can choose from two payment options:

☐ Accepted Insurance Plan

☐ Cash, Check, Credit Card (Visa, MasterCard, American Express, Discover)

For patients with medical insurance we are happy to work with your carrier to maximize your benefit and direct bill them for reimbursement for your medical treatment. However, if we do not receive full payment from your insurance carrier within 90 days of the date of service, you will be responsible for payment of all your treatment fees and the collection of your benefits directly from your insurance carrier.

If you are covered by one of our accepted insurance plans, and can provide a valid insurance card or other evidence of coverage at or before the time of service, we will bill your insurance carrier for your non-cosmetic dermatology services. These dermatology services may be applied towards your deductible, subject to copayment or coinsurance, in which case you will be financially responsible. You are responsible for knowing the policies of your insurance, such as: co-pay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, in-network physicians, etc. All copayments must be paid on the date of service. If you have an HMO insurance you are responsible for your referrals. Referrals are typically only valid for 90 days from the issue date and are only good for as many visits as your primary care physician has approved. It is the patient's responsibility to see if we are in network.

For surgery patients with a High Deductible Health Care Plan (HDHP), equal to $1500 or more, the total payment for the procedure will typically be your personal out-of-pocket expense unless your high deductible has been met. For Mohs surgery patients with HDHP we ask that you pre-pay a portion of your surgery in the amount of one thousand ($1000) dollars prior to the procedure which will go toward your anticipated balance. For surgery patients having an excision, you will be asked to pre-pay five hundred ($500) dollars on the day of your surgery. Any remainder is due within 90 days of your surgery if you have not met your high deductible.

If you have a balance due after your insurance compensates the Practice for its portion of your care, your balance ***must*** be paid within 90 (ninety) days or your account will be turned over to our collection agency. The Practice may make an exception to this based on your financial

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Patient Responsibility Policy

Patients who cancel, miss, or reschedule appointments without giving 24 hour notice will be charged a missed appointment fee. This fee depends on the type of visit. For missed surgical visits (Mohs micrographic surgery, Excision) a $100 fee will be applied. Routine office visits will incur a $50 fee.

For self-pay patients, Darius J. Karimipour, M.D., P.C. requires payment in full on the day of your treatment by Cash, Check, or Credit Card. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

All prices quoted prior to the completion of non-cosmetic dermatology office visits and procedures are only estimates and can change based on the complexity of the office visit and/or procedures performed during the date of service.

If a tissue specimen is sent to a pathology lab you will be billed separately for that additional procedure.
Payment for cosmetic treatments is due in full at the time of service.

Darius J. Karimipour, M.D., P.C. charges a $30 fee for returned checks.

My signature states that I have read and fully understand the above patient responsibility policy and agree to its terms:

_____

Patient, Parent, or Guardian Signature **Date**

_____

Patient Name (Please Print)