BEVERLY HILLS MEDICAL MANAGEMENT, INC.

Eric A. Lewis, M.D.
125 North Robertson Blvd., Beverly Hills, CA 90211

For Office Use Only:	
❑ New Patient	❑Update
Entered In System by:	

(Please Print Clearly in Black Ink)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security no.:	Birth date:	Age:	Sex: ❑ M ❑ F

Home Address:	City:	State:	Zip Code:
Billing Address:	City:	State:	ZIP Code:

Home no.: ( )	Cell no.: ( )	Email Address:
Occupation:	Employer:	Employer phone no.: ( )

Is it ok to leave information regarding appointments on your voicemail?	❑ Yes ❑ No		
How did you hear about us?	❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work	❑ Website	❑ Other	

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD & DRIVER'S LICENSE TO THE RECEPTIONIST FOR PHOTOCOPYING)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Policy no.:	Group no.:	Co-payment: $

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

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

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

IN CASE OF EMERGENCY

Emergency Contact:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I, the undersigned, authorize the release of my medical information to Dr. Lewis, and as necessary to process insurance claims, and prescriptions. I understand that I am financially responsible for any and all charges incurred whether or not paid by my insurance company. This includes deductibles, copayments, and any procedure deemed by my insurance company to be cosmetic or medically unnecessary.

I authorize use of this signature on all insurance claim submissions. I assign directly to Eric A. Lewis, MD and/or Beverly Hills Medical Management Corp., all medical benefits, if any, otherwise payable to me for services rendered by Dr. Lewis.

I understand the if **ALL of the above information is not completed, or if I do not furnish this office with my insurance card,** this office will be unable to submit claims to my insurance company, therefore I will be required to pay for all services rendered by cash, check, or credit card.

_____ _____

Patient/Guardian signature ***Date***

THIS OFFICE DOES NOT ACCEPT HMO or MEDI-CAL INSURANCE

MEDICAL HISTORY

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list:

1. _____ 3. _____
2. _____ 4. _____

List all medications you are currently taking:

1. _____ 3. _____
2. _____ 4. _____

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

Lungs:	**Yes**	**No**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Vascular:		
High Blood Pressure	☐	☐
Chest pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Pacemaker	☐	☐
Phlebitis	☐	☐

Other Systemic:	**Yes**	**No**
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Stomach	☐	☐
Bowel	☐	☐
Hepatitis or Yellow Skin	☐	☐
Glaucoma	☐	☐
Arthritis/Joint Deformity	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

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 been exposed to HIV (AIDS)? ☐ Yes ☐ No
Have you ever had dental anesthesia (Novocain)? ☐ Yes ☐ No Any Bad Reaction? ☐ Yes ☐ No

Skin:

When you are exposed to the sun do you: ☐ Tan Only ☐ Tan & Burn ☐ Burn
Have you ever had skin cancer? ☐ Yes ☐ No
Has anyone in your family ever had skin cancer? ☐ Yes ☐ No
Do you have a history of any skin diseases? ☐ 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:

Do you smoke? ☐ Yes ☐ No
Do you bleed easily? ☐ Yes ☐ No
(Women) Are you pregnant? ☐ Yes ☐ No
Do you have artificial joints? ☐ Yes ☐ No

What is your occupation? _____

What are your hobbies? _____

This form was completed by:

☐ Patient
☐ Medical Assistant _____ (initial)

HIPAA CONSENT

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 rights 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 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 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice 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
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name- Patient of Representative

_____

Signature **Date**

Relationship to Patient: _____
(if other than the Patient)

Witness: _____

Printed Name- Practice Representative

_____

Signature **Date**

MARKETING CONSENT

"I understand the Dr. Lewis may occasionally be offering special promotions, events, discounts, or the announcement of new cosmetic treatments, services, or products that I may find of interest.

My signature below gives permission for Dr. Lewis' office to send me, at the main mailing address that I have provided on my registration form, any such announcements at their discretion. This mailing may be in letter or postcard form.

I understand that the information contained in these mailings may be about procedures that I have already performed, about special events or discounts, or may be regarding other cosmetic services or products that Dr. Lewis may feel may be of interest to me. I understand that this permission is good until such a time as I revoke it in writing."

I understand that Dr. Lewis may also use the email address provided on my registration form for the promotion and marketing described above.

This Consent was signed by: _____

Printed Name- Patient of Representative

_____

Signature **Date**

Relationship to Patient: _____
(if other than the Patient)

Witness: _____

Printed Name- Practice Representative

_____

Signature **Date**

FINANCIAL AGREEMENT

1. I understand that as a courtesy Beverly Hills Medical Management, Inc. will be happy to file my insurance claim for covered services rendered at this office. This service is outsourced to a billing company, Rancho Billing, and they will be happy to answer any questions I may have. I understand that Medicare, insurance companies, my employer, and other payers may have restrictions on reimbursement for medical care and these may include the need for authorizations or referrals, the use of designated facilities or laboratories, non-covered services, deductibles, co-payments and other requirements. I understand that it is my responsibility to be familiar with and comply with such restrictions and that I will be personally responsible for any charges not reimbursed by other payers. By signing below, I authorize payment of medical benefits to Beverly Hills Medical Management, Inc. for medical services I or my dependents receive at this office. With this knowledge, I also understand that I am personally responsible for charges incurred for medical care rendered by Beverly Hills Medical Management, Inc. and it is my responsibility to be familiar with medical insurance company's rules and restrictions if I am to expect reimbursement from them.

2. I understand that it is solely my responsibility to determine if Beverly Hills Medical Management, Inc. is a preferred provider for my particular insurance plan. They are a preferred provider for most PPO insurance plans, unions, and Medicare. They are not providers for Medi-Cal or HMO insurance plans. If I do not have insurance, the services rendered are non-covered or "cosmetic," my insurance is not accepted here I will be responsible for all charges.

3. I certify that all information given by me to bill Medicare, insurance companies, my employer and other payers is correct, complete, and up to date. I understand that it is my responsibility to notify Beverly Hills Medical Management, Inc. of a change in my address or any change to my medical insurance policy or carrier. I understand that payers may have time limits for filing claims and providing incorrect and/or incomplete information may result in denial of reimbursement for which I will be personally responsible. I understand that if I have an outstanding bill and fail to notify Beverly Hills Medical Management, Inc. of any change to my address, my account will likely end up in collections if they are unable to locate me.

4. I understand that Beverly Hills Medical Management, Inc. has a cancellation policy. If I am unable to keep my appointment, I will cancel my appointment at least 24 hours in advance to allow that time to be filled by someone else with an urgent need to see the doctor. I understand that if I do not show up for my scheduled appointment, my account will be charged $20 for office visits and $50 for surgical appointments. I understand this policy has been put in place to allow this office to serve as many people in the community as possible while keeping waiting time to a minimum.

I acknowledge that I understand all of the above and agree to abide by the terms of this document.

_____ _____

Signature (Self/Parent/Guardian) **Date**