889 Castro Street
Mountain View, CA 94041
p (650) 969-5488
f (650) 969-7546

KHUU
DERMATOLOGY

200 Jose Figueres Ave #465
San Jose, CA 95116
p (408) 729-5488
f (408) 729-1958

KHUU DERMATOLOGY PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: ____ Date of Birth: ___________ Gender: M/F
Last First Middle Initial

Address: _________________________________Apt #:______City:__________________State:_____ Zip: ___

Primary Phone #: (_____)_____________________ Secondary Phone #: (______)___________________________

Email: ___________________________________ Would you like to be added to our mailing list? ☐ ☐

If we need to reach you, may we leave confidential voicemail messages at the above numbers? ☐ ☐

Primary Care/Referring Physician: ______________________________ Phone #: _________________________

List of medications: ____

Emergency Contact/Relationship: _____ _________________________ Phone#: __________________________

Primary Language: ____
Spoken Written

Racial/Ethnic Identity: ☐ Asian/Pacific Islander ☐ Black/African American ☐ Caucasian/White
☐ Hispanic/Latino ☐ Native American/American Indian ☐ Other: ____________

Interested in treatments for wrinkles, laser hair removal, lasers for red and brown spots, skincare, or leg veins? Y N

INSURED / RESPONSIBLE PARTY (please complete all entries even if a copy of the insurance card has been provided to us)

Name of Primary Insurance: _______________________ Name of Secondary Insurance: ____________________

(If HMO, please enter the Medical Group Name i.e. Affinity, Alameda Alliance, Medicare, NorCal, Physician Medical Group, SCCIPA, Tricare)

Subscriber/Member ID: __________________________ Subscriber/Member ID: __________________________

Subscriber/Member Name: _______________________ Subscriber/Member Name: _______________________

Subscriber Birthdate: ___________________________ Subscriber Birthdate: ___________________________

Relationship to patient: ☐ lf ☐ ouse ☐ rent ☐ ther Relationship to patient: ☐ lf ☐ ouse ☐ rent ☐ her

Do you have a Health Saving Account? Y N

ASSIGNMENT and RELEASE of INSURANCE BENEFITS

I hereby assign my insurance benefits to be paid directly to Dr. Duke T. Khuu, MD doing business as Khuu Dermatology and authorize Khuu Dermatology/Dr. Duke T. Khuu, MD, to release my insurance and any information required to process claims for services rendered. I understand if claims are denied due to any reasons, I will assume full responsibility for all charges incurred by me and all dependents. Additionally, I will be financially responsible for any non-covered benefits, deductibles, or any copayments for services, which have been provided to me. This assignment will remain in effect until revoked by me in writing. I also consent Dr. Khuu and his assistant for all recommended treatments.

Patient Initials: ☐

Financial and Miscellaneous Policies of Khuu Dermatology

Insurance Patients – PPO/HMO/Medicare:

1. If your insurance requires a referral/authorization from your primary care physician (PCP), you must present your authorization prior to your exam. If you are unable to provide us with your authorization, we will gladly contact your PCP for you, or if he/she is unavailable, will reschedule your appointment for a time that is convenient for you.
2. All copays are due at the time of the visit. Copays cannot be waived as we are a contracted provider.
3. If your health plan has an annual deductible which has not been satisfied, then we collect partial amount at the time of the visit. If your insurance company determines that the deductible is not applicable for the services provided, we will refund you any remaining amount.
4. If copays and/or deductibles are not paid at the time of the visit, you will be assessed a $10 surcharge.
5. If you are unable to provide your insurance information or we are unable to confirm your insurance status, you will be treated as a Private Pay Patient at the time of your visit and you will be responsible for a payment at the time of service (please see Private Pay Patient below).

Private Pay Patients:

1. If we are not contracted with your insurance, or you do not have insurance, you are responsible for payment at the time of service. You may request for an itemized bill before leaving the office.

Aesthetic services:

1. Some insurance companies may consider some of our aesthetic treatments such as chemical peel and acne extraction as cosmetic treatment and may not be covered. As a professional courtesy, we will submit the claims to your insurance, but you will be responsible for any services that are denied.

Refund policy/Cancellation Policy/Return Checks/Collections:

1. No refunds for medical/cosmetic procedures. Exchange or refund for products within 7 days of purchase. Prescription products are not refundable or returnable.
2. To avoid $50 fee ($100 for surgical appointment), please call 24 hours in advance to cancel or re-schedule your appointment. You will be billed directly for any missed appointments and are due within 30 days or before your next appointment, whichever comes first.
3. A charge of $30 will be made for all returned checks or unjustified credit card charge dispute.
4. As a professional service, we will make every attempt to contact you for payments. If you fail to pay, you will be sent to collection agency for any outstanding balances.

HIPPA Regulations:

We comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations. We will not release confidential and/or other Protected Health Information without your consent. Your signature below acknowledges our communication to you regarding this matter.

All information I have filled out is correct. My signature indicates my understanding and responsibility for all statements on these pages.

Patient/Responsible party Signature: ____***Date:***______________