REDDING DERMATOLOGY MEDICAL GROUP, INC.
2107 AIRPARK DRIVE - REDDING, CA 96001

WWW.CKDERM.COM

PATIENT ACCOUNT NUMBER:	DATE COMPLETED / UPDATED:	**FOR INTERNAL USE:** ☐ **SCANNED** **INITIALS:** ___________

PATIENT NAME (FIRST - MIDDLE - LAST):	PREFERED NAME:

SEX (ASSIGNED AT BIRTH):	GENDER IDENTITY:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	DRIVER'S LICENSE NUMBER/STATE:

RACE:

☐ Caucasian ☐ Asian ☐ Hispanic ☐ Latino ☐ American Indian ☐ Black ☐ Pacific Islander/ Hawaiian ☐ Other: ____________________________

BILLING MAILING ADDRESS (STREET / P.O. BOX - CITY - STATE - ZIP):

PHYSICAL ADDRESS (STREET - CITY - STATE - ZIP):

EMAIL ADDRESS:

HOME PHONE NUMBER:	WORK PHONE NUMBER:	CELL PHONE NUMBER:

PREFERRED METHOD OF CONTACT:

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

MARITAL STATUS: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Name of Significant Other (if applicable): ____________________________	WORK STATUS: ☐ Student ☐ Homemaker ☐ Unemployed ☐ Retired ☐ Employed - ☐ Full-Time ☐ Part Time ☐ Self

OCCUPATION:	EMPLOYER/COMPANY NAME:

EMPLOYER ADDRESS (STREET - CITY - STATE - ZIP):

EMERGENCY CONTACT (NAME / RELATIONSHIP):	EMERGENCY CONTACT PHONE NUMBER:

(IF PATIENT IS A MINOR) RESPONSIBLE PARTY (NAME / RELATIONSHIP):	RESPONSIBLE PARTY PHONE NUMBER:
(IF APPLICABLE) POWER OF ATTORNEY NAME:	POWER OF ATTORNEY PHONE NUMBER:
(IF CARE HOME RESIDENT) CARE HOME NAME / CONTACT NAME:	CARE HOME CONTACT PHONE NUMBER:

APPOINTMENT REMINDER CALLS

- ☐ Phone call to the following number: ____________________
- ☐ Text message to the following number: ____________________
  - ☐ I consent to receive appointment text messages for my appointment reminders. I understand I may be charged by my wireless carrier and that such calls/text messages may be generated by an automated system.
- ☐ Email to the following email address: ____________________

CONSENT TO DISCLOSE HIPAA PROTECTED HEALTH INFORMATION

May we inform you of results that are benign or do not need further treatment through our patient portal? ☐ YES ☐ NO

Note: we will always call to inform of results that need further or follow-up treatment

May we leave a detailed message regarding an appointment or biopsy/lab results on your phone? ☐ YES ☐ NO

If yes, on which phone may we leave a detailed message? ☐ home ☐ cell ☐ work

May we discuss your medical information with your spouse, family member, or friend? ☐ YES ☐ NO

If yes, name/relationship ____________________

If yes, what may we discuss? ☐ appointment information ☐ biopsy/lab results ☐ billing information

May we forward by mail/fax/email a copy of your medical information (biopsy/lab results) to you? ☐ YES ☐ NO

If yes, please complete authorization form below. If no, please leave blank.

May we forward by mail/fax/email a copy of your medical information (biopsy/lab results) to another provider? ☐ YES ☐ NO

If yes, please complete authorization form below. If no, please leave blank.

AUTHORIZATION TO RELEASE/REQUEST MEDICAL INFORMATION

I hereby authorize Redding Dermatology Medical Group, Inc. to release my medical records (including chart notes, lab/biopsy results, and billing information) to:

(1) ____________________
NAME

____
ADDRESS

____________________ ____________________
PHONE FAX

(2) ____________________
NAME

____
ADDRESS

____________________ ____________________
PHONE FAX

Please print patient name and date of birth below, then sign.
I understand that this authorization will expire two (2) years from the date below.

____________________ ____________________
PATIENT NAME DATE OF BIRTH

____________________ ____________________
PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

____________________ ____________________
WITNESS SIGNATURE **DATE**

NOTICE TO CONSUMERS
MEDICAL DOCTORS AND THEIR ASSOCIATES ARE LICENSED AND REGULATED BY
THE MEDICAL BOARD OF CALIFORNIA
(800) 633-2322
WWW.MBC.CA.GOV

Do you have medical insurance coverage? ☐ YES ☐ NO

PRIMARY INSURANCE NAME:	
POLICY / ID NUMBER:	GROUP NUMBER:
SUBSCRIBER NAME:	SUBSCRIBER'S RELATIONSHIP TO PATIENT:
SUBSCRIBER'S SOCIAL SECURITY NUMBER:	SUBSCRIBER'S DATE OF BIRTH:
SUBSCRIBER'S EMPLOYER:	

SECONDARY INSURANCE NAME (IF APPLICABLE):	
POLICY / ID NUMBER:	GROUP NUMBER:
SUBSCRIBER NAME:	SUBSCRIBER'S RELATIONSHIP TO PATIENT:
SUBSCRIBER'S SOCIAL SECURITY NUMBER:	SUBSCRIBER'S DATE OF BIRTH:
SUBSCRIBER'S EMPLOYER:	

Are you covered by a separate prescription drug benefit plan? ☐ YES ☐ NO

PRESCRIPTION DRUG BENEFIT PLAN / PHARMACY BENEFIT MANAGER NAME:	
PRESCRIPTION POLICY / ID NUMBER	GROUP NUMBER:

Are you being seen due to an injury that occurred at work? ☐ YES ☐ NO

Are you currently eligible and/or receiving any state/government issued health insurance? ☐ YES ☐ NO

MEDICARE PATIENTS ONLY

Are you covered by a PPO/HMO that makes Medicare secondary? ☐ YES ☐ NO

Are you covered by the VA (Veteran's Administration)? ☐ YES ☐ NO

Are you covered by the Federal Black Lung or End Stage Renal Disease Program? ☐ YES ☐ NO

Are you or your spouse currently working and getting insurance from a company with 20 or more employees? ☐ YES ☐ NO

CONSENT FOR ALL PATIENTS

Insurance Billing Authorization and Acknowledgement of Financial Responsibility: I hereby authorize Redding Dermatology Medical Group, Inc. to furnish my insurance company with any information necessary for reimbursement of professional services rendered.
I assign medical benefits to be paid directly to Redding Dermatology Medical Group, Inc., so that my insurance company may be billed directly. I realize that I am responsible for all non-covered services and any charges not covered by this assignment. I assume responsibility for charges if my insurance chooses not to pay within 90 days of the billing date.

____ ________________________

SIGNATURE OF PATIENT/RESPONSIBLE PARTY **DATE**

Patient Name: ______________________________ **DOB:** ________________ **Date Completed:** ______________________

Please list/describe the skin condition/concern you would like us to evaluate/treat:

____

____

Please list any past surgeries, hospitalizations, traumas, or serious illnesses:

____

____

Please list all medications/supplements you are currently taking:

____

____

Please list all medications/supplements you have taken but have discontinued in the last three months:

____

____

Primary Care Physician Name: ____

Referring Physician Name: ____

Preferred Retail Pharmacy: ____

Preferred Mail Away Pharmacy: ____

Please estimate your height: ________________________ Please estimate your weight: ____________________

MEDICAL HISTORY (please check all that apply):

EYES:

- ☐ Visual Changes
- ☐ Double Vision
- ☐ Floaters
- ☐ Pain
- ☐ Redness
- ☐ Cataracts
- ☐ Lens Replacement Surgery
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Blindness
- ☐ Wear Glasses
- ☐ Wear Contact Lenses
- ☐ LASIK
- ☐ PRK
- ☐ Other Eye Surgery/Procedure ____________________

EARS/NOSE/THROAT/MOUTH:

- ☐ Hearing Difficulties
- ☐ Wear Hearing Aids
- ☐ Runny Nose
- ☐ Congestion/Stuffiness
- ☐ Nose Bleeds
- ☐ Sinus Pain
- ☐ Tinnitus (Ringing in Ears)
- ☐ Earache
- ☐ Toothache
- ☐ Sore Throat
- ☐ Wear Dentures
- ☐ Dry Mouth
- ☐ Cold Sores
- ☐ Canker Sores

CARDIOVASCULAR:

- ☐ Chest Pain/Tightness
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Irregular Heartbeat/Palpitations
- ☐ Heart Bypass
- ☐ Stent
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Heart Attack
- ☐ Cardiogram
- ☐ Angiogram
- ☐ Other Heart Surgery/Procedure ____________________

VASCULAR:

- ☐ Varicose Veins
- ☐ Vascular Ablation/Surgery
- ☐ Edema

GASTROINTESTINAL:

- ☐ Ulcers
- ☐ Abdominal Pain
- ☐ Weight Loss
- ☐ Indigestion/Acid Reflux/GERD
- ☐ Eating Disorder - ____________________________
- ☐ Nausea/Vomiting
- ☐ Gall Stones
- ☐ Diarrhea/Constipation
- ☐ Colitis - _________________________________
- ☐ Irritable Bowel Disease
- ☐ Crohn’s Disease
- ☐ Gastric Bypass/Procedure

ENDOCRINE:

- ☐ Diabetes - ☐ Type I ☐ Type II
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hypoglycemia
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ Kidney Infection
- ☐ Kidney Disease / Failure
- ☐ Kidney Transplant
- ☐ Thyroid Disorder - ☐ Hypothyroidism ☐ Hyperthyroidism
- ☐ Hyperhidrosis
- ☐ Hormone Replacement Therapy

INTEGUMENTARY:

- ☐ Dermatitis (rash)
- ☐ Pruritus (itch)
- ☐ Atopic Dermatitis (eczema)
- ☐ Dry Skin
- ☐ Psoriasis
- ☐ Seborrheic Dermatitis
- ☐ Tinea Versicolor
- ☐ Perioral Dermatitis
- ☐ Rosacea
- ☐ Acne
- ☐ Keloids (raised painful scarring)
- ☐ Herpes Zoster (shingles)
- ☐ Herpes Simplex Virus - ☐ Type I ☐ Type II
- ☐ Vitiligo
- ☐ Cysts - ☐ Epidermal ☐ Pilar
- ☐ Lipomas
- ☐ Hair Loss - ☐ Thinning ☐ Alopecia
- ☐ Urticaria (hives)
- ☐ Nail Condition: ______________________________
- ☐ Seborrheic Keratosis
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
  - Location(s): ______________________________
  - Treatment: ______________________________
- ☐ Squamous Cell Carcinoma
  - Location(s): ______________________________
  - Treatment: ______________________________
- ☐ Melanoma
  - Location(s): ______________________________
  - Treatment: ______________________________
- ☐ Melanoma In Situ
  - Location(s): ______________________________
  - Treatment: ______________________________
- ☐ Wound/Laceration
  - Type: ______________________________
  - Location: ______________________________
- ☐ Infection - ☐ Bacterial ☐ Viral ☐ Fungal
- ☐ Excision
  - Type: ______________________________
  - Location: ______________________________
- ☐ Cosmetic Surgery/Procedure
  - Type: ______________________________
- ☐ Laser Procedure
  - Type: ______________________________

NEUROLOGIC:

- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Headaches
- ☐ Seizures
- ☐ Dizziness/Lightheadedness
- ☐ Vertigo
- ☐ Fainting
- ☐ Speech Condition
- ☐ Paralysis
- ☐ Stroke
- ☐ Numbness/Tingling of Limbs
- ☐ Tremor
- ☐ Cerebral Palsy
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis

PSYCHIATRIC:

- ☐ Depression
- ☐ Anxiety
- ☐ Paranoia
- ☐ Stress
- ☐ Memory Loss
- ☐ OCD
- ☐ Schizophrenia
- ☐ Dementia
- ☐ Alzheimer's Disease

RESPIRATORY:

- ☐ Exposure to Tuberculosis
- ☐ Last Date/Result of PPD ______________________________
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Oxygen Dependent
- ☐ Use CPAP
- ☐ Pneumonia
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Lung Disease

MUSCULOSKELETAL:

- ☐ Use Wheelchair/Walker
- ☐ Joint Stiffness/Pain
- ☐ Muscle Pain/Weakness
- ☐ Arthritis - ☐ Osteo ☐ Rheumatoid ☐ Psoriatic
- ☐ Multiple Sclerosis
- ☐ Bone Disease
- ☐ Gout
- ☐ Joint Replacement ______________________________
- ☐ Trauma/Broken Bones ______________________________
- ☐ Back Surgery/Procedure ______________________________

HEMATOLOGIC/LYMPHATIC:

- ☐ Easy Bruising
- ☐ Easy Bleeding
- ☐ Blood Clots
- ☐ Cancer
  - Type: ____
  - Treatment: ____________________________________
- ☐ Lupus
- ☐ Anemia
- ☐ Use Anticoagulant/Antiplatelet Drug
- ☐ Blood Transfusion
- ☐ Refusal to Donate or Accept Blood
- ☐ Do Not Resuscitate Orders
- ☐ HIV
- ☐ AIDS
- ☐ Hepatitis - ☐ Type A ☐ Type B ☐ Type C
- ☐ Liver Disease/Failure
- ☐ Liver Transplant

GENITOURINARY (MALE):

- ☐ Trying to Conceive
- ☐ Hernia
- ☐ Urinary Incontinence
- ☐ Infections
- ☐ Herpes Simplex Virus - ☐ Type I ☐ Type II
- ☐ Condyloma/Genital Warts
- ☐ Other Sexually Transmitted Disease: ____________________

GENITOURINARY (FEMALE):

- ☐ Trying to Conceive
- ☐ Pregnant - Due Date ______________________________
- ☐ Breast Feeding
- ☐ Use Contraception - Form: _________________________
- ☐ Irregular Menses
- ☐ Polycystic Ovarian Syndrome
- ☐ Menopause
- ☐ Urinary Incontinence
- ☐ Infections - ☐ Yeast ☐ Urinary ☐ Bladder ☐ Kidney
- ☐ Herpes Simplex Virus - ☐ Type I ☐ Type II
- ☐ Condyloma/Genital Warts
- ☐ Sexually Transmitted Disease: ________________________

ALLERGIC /IMMUNOLOGIC:

- ☐ Swollen Lymph Node/Gland
- ☐ Autoimmune Disorder: ____________________________
- ☐ Hives – List cause if known:___________________________
- ☐ Anaphylaxis – List cause if known: ____________________
- ☐ Food Allergy: ____
- ☐ General Allergy: _____________________________________
- ☐ Medication Allergy: __________________________________
- ☐ Hay Fever
- ☐ Other Allergy: ____

FAMILY HISTORY:

☐ Skin Cancer	Relation: ______________________________
☐ Cancer	Relation: ______________________________
☐ Psoriasis	Relation: ______________________________
☐ Diabetes	Relation: ______________________________
☐ Autoimmune Disorder	Relation: ______________________________

SOCIAL/PERSONAL HISTORY:

☐ Exercise:	Type: ____________________	Frequency: ____________________
☐ Caffeine:	Type: ____________________	Frequency: ____________________
☐ Tobacco:	Type: ____________________	Frequency: ____________________
☐ Alcohol:	Type: ____________________	Frequency: ____________________
☐ Recreational Drugs:	Type: ____________________	Frequency: ____________________

REDDING DERMATOLOGY MEDICAL GROUP, INC.

HIPAA NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information, "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other required by law. Storage and office placement of medical records will be protected according to the laws in this "Notice of Privacy Practices". Our files do not have doors or covers; however, only authorized personnel will be allowed access.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization: as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation.

Inmates: Required Uses and Disclosures; Under the law we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibited access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Provider.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You will be charged for record copies.

You may have the right to have your physician amend your protected health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our HIPAA Compliance Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Your physician has the right to terminate your healthcare for non-compliance to treatment.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

This notice became effective on April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

____ _______________________

SIGNATURE OF PATIENT/RESPONSIBLE PARTY **DATE**

REDDING DERMATOLOGY MEDICAL GROUP, INC.

PATIENT FINANCIAL AGREEMENT AND ACKNOWLEDGMENT OF OFFICE POLICIES

Registration: All patients must complete our patient information forms and maintain accurate information for proper communication and billing. To provide proof of insurance, patients must provide a current valid insurance card and government issued photo ID. Copies of these cards will be taken and kept in your records.

Insurance: We accept Medicare assignment and participate in most insurance plans. If you fail to provide correct insurance information or your insurance changes and you fail to promptly notify us, you may be responsible for the balance of a claim. Most insurance companies have claim filing time restrictions; if a claim is not received within 30 days of the date of service, it may be ineligible for payment and you will be responsible for the remaining balance. You are responsible for all non-covered services and any charges not covered by this assignment, including applicable copayments and deductibles. **Copayment is due at the time of service. If you cannot pay your copayment at the time of service, your appointment will be rescheduled.**

Uninsured and Cosmetic Patients: Payment is due at the time of service – no exceptions.

Patient Appointments: Two days prior to your appointment you will receive a call or text message confirming your appointment. If you need to cancel your appointment, we ask that you give us as much notice as possible so we are able to fill your appointment spot with a patient on our cancellation list. Patients arriving later than 15 minutes past their scheduled appointment time will be subject to rescheduling per the provider's discretion.

Missed Appointment Fees: Our policy is to charge $25 after the first missed appointment not canceled within one business day or 24 hours before your appointment time, whichever is longer. After a second missed appointment, this fee will be $50. Missed appointment fees will be your responsibility and billed directly to you. This fee must also be settled prior to scheduling with us again. We understand that emergencies occur and will take these situations on a case by case basis. Please help us serve you better by keeping your scheduled appointments.

Scheduled Surgeries/Procedures: If your physician recommends a scheduled surgery/procedure, your account will be forwarded to our surgery coordinator to check your eligibility and benefits. Our surgery coordinator will obtain a cost estimate which shows your financial responsibility, based on the benefit levels and coverage of your insurance plan and complete all pre-certification/authorization if your insurance company requires it. You will be contacted by our surgery coordinator to go over any prep that may be required, answer any questions you may have, and to collect a pre-surgical deposit. This deposit amount will depend on your coverage and deductible amount. No showing a scheduled surgery/procedure or cancellation less than 24hrs prior will result in a $50 fee, that will be due before scheduling again.

Billing: Statements are sent out monthly. Payment is due upon receipt of statement. Payment may be made on our Patient Portal, by mail, by calling our billing office at (530) 241-7098, or in person at any of our office locations. If you elect, you may choose to save a credit card on file and set up an autopayment for balances less than $10.

Minors: A parent/legal guardian must accompany any patient under the age of 18 on the patient's first visit. This accompanying adult is responsible for payment of the account, according to office policy. Minors are permitted to come to subsequent appointments without their parent or legal guardian provided they are able to settle any payment that is due.

Treatment: During your visit your provider may recommend treatment to you and ask for your verbal consent to treatment. By this verbal agreement, you authorize Craig A. Kraffert, M.D., and/or his associates, assistants of his choice, and personnel assigned by him to perform the agreed upon procedure and/or to do any other procedures that in his judgement may be medically necessary for your wellbeing. These procedures include those advisable to remedy conditions discovered during the procedure or operation, including but not limited to, the selection and administration of anesthesia, the performance of pathology services, and the disposal of any severed tissue in accordance with accustomed medical practice. All patients understand there are risks associated with any procedure including the potential for serious harm, wound infection, anesthesia risks, and even death. No warranty or guarantee has been made as to the result or cure.

I hereby agree to the above financial agreement and office policies of Redding Dermatology Medical Group, Inc.

____ ____________________

SIGNATURE OF PATIENT/RESPONSIBLE PARTY **DATE**