Ileana E. Zapatero, M.D.
Wendi Schulze, NP-C
Diplomates, American Board of Dermatology
Diseases and Surgery of the Skin, Skin Cancer

OFFICE POLICY
REGARDING MEDICAL INSURANCE & PAYMENT

We are NOT preferred providers for any insurance companies.

Payment is required at the time services are provided.
We accept all major credit cards, checks and cash (please be advised that we do not carry any amount of change).

We are happy to provide you with a super bill of your visit to submit to your insurance company, however we cannot make any guarantee that you will be reimbursed in full or at all.

We strive to deliver the highest quality care possible. In order for us to provide optimal service to our patients, we kindly ask that cancellations be made at least 24 hours prior to your appointment time.

When cancellations occur within 24 hours of an appointment, or an appointment is missed, patients will incur a $75.00 fee at their next visit.

Thank you for your continued compliance.

I have read and understand the above office policy.

_____ Signature / Date _____

910 via de la Paz #205 | Pacific Palisades, CA 90272 | 310- 454-5555

Ileana E. Zapatero, M.D.
Wendi Schulze, NP-C

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Ileana E. Zapatero, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Ileana E. Zapatero, M.D.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Ileana E. Zapatero, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Ileana E. Zapatero, M.D. Privacy Officer at 910 Via de la Paz, Suite 205, Pacific Palisades, CA 90272.

With this consent, Ileana E. Zapatero, M.D. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Ileana E. Zapatero, M.D. may send to my email address mail to my home or other alternative location, any information or items that assist in the practice carrying out TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Ileana E. Zapatero, M.D.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Ileana E. Zapatero, M.D. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Patient's Name

_____

Print Name of Patient or Legal Guardian

Ileana E. Zapatero, MD
Wendi Schulze, NP-C

CLINICAL INFORMATION AND MEDICAL HISTORY

Name _____ Date_____

Date of Birth_____ Sex □M □F Height _____Weight_____

Allergies to Medication(s):_____

Medication(s) in Use: _____

Name & Telephone Number of Family Physician:_____

Any Current or Recent Medical Problems:_____

Do you have, or have you ever had, any of the following:

□	Skin Cancer	□	Anemia
□	Diabetes	□	Seizures
□	Heart Problems	□	HIV/AIDS/ARC
□	Hepatitis	□	Mitral Valve Prolapse
□	Hypertension	□	Pacemaker
□	Asthma	□	Other; Please Explain

_____

Are you pregnant or nursing ? □ Yes □ No

For what condition are you seeking treatment?_____

If seeking cosmetic consult have you ever had: □ Botox □ Filler □Laser □ Chemical Peel (Check All That Apply)

Your preferred pharmacy (prescriptions) _____

Patient Signature: _____ Date: _____

Ileana E. Zapatero, MD
Wendi Schulze, NP-C

PATIENT DATA

Name:_____ Sex : □Male □Female

Address:_____City_____Zip_____

Email:_____

□Home Phone :_____ □Work:_____□Cell: _____
Please check preferred contact number May we leave a voicemail**? Yes / No**

Date of Birth _____ Marital Status: Single /Married /Separated/Divorced/Widowed

Name of Spouse (if married) or Parent (if minor)_____

Employer_____Occupation_____

Employer Address_____

Person(s) we may discuss your medical information with:_____

****Emergency Contact**_____Relationship_____Phone_____

****Referred by** _____

INSURANCE DATA

Primary Carrier_____

Address_____

Insured's Name_____ Group# _____Policy#_____

Secondary Carrier_____

Address_____

Insured's Name_____ Group# _____Policy#_____

FINANCIAL POLICY
We request that payment be made at the time services are rendered. If you carry health insurance, you should understand that all services furnished are charged directly to you and that you are responsible for payment. Your policy is a contract between you and your insurance company.

I have read and agree to the terms here and authorize Ileana E. Zapatero, MD to release to my insurance carrier any information required to process an insurance claim. Further, I authorize my insurance carrier to make direct payment to Ileana E. Zapatero, MD.

Signature_____ Date_____