



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

WWW.CKDERM.COM

DATE COMPLETED / UPDATED:		<b>FOR INTERNAL USE:</b>		
		PATIENT ACCOUNT NUMBER: _____		<input type="checkbox"/> <b>SCANNED EMR</b>
PATIENT NAME (FIRST - MIDDLE - LAST):			PREFERRED NAME:	
SEX (ASSIGNED AT BIRTH):	GENDER IDENTITY:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	DRIVER'S LICENSE NUMBER/STATE:
RACE: <input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Latino <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander/Hawaiian <input type="checkbox"/> Other: _____				
BILLING MAILING ADDRESS (STREET / P.O. BOX - CITY - STATE - ZIP):				
PHYSICAL ADDRESS (STREET - CITY - STATE - ZIP):				
EMAIL ADDRESS (NEEDED FOR APPOINTMENT REMIINDERS):				
HOME PHONE NUMBER:		WORK PHONE NUMBER:		CELL PHONE NUMBER (NEEDED FOR TEXT REMIINDERS):
PREFERRED METHOD OF CONTACT: <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email				
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Name of Significant Other (if applicable): _____			WORK STATUS: <input type="checkbox"/> Student <input type="checkbox"/> Homemaker <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Employed - <input type="checkbox"/> Full-Time <input type="checkbox"/> Part Time <input type="checkbox"/> 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**

Voice call to  home  cell  work

Text message to cellphone number on file

I consent to receive appointment text messages. I understand I may be charged by my wireless carrier and that such text messages may be generated by an automated system.

Email to address on file

**CONSENT TO DISCLOSE HIPAA PROTECTED HEALTH INFORMATION**

May we inform you of results that are benign or do not need follow-up treatment through an automated system?  YES  NO

Note: we will always call to inform of results that need 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 the 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 the authorization form below. If no, please leave blank.

**AUTHORIZATION TO RELEASE/REQUEST MEDICAL INFORMATION**

I hereby authorize CK Derm 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

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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date Completed: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

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**MEDICAL HISTORY** (please check all that apply):

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**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 \_\_\_\_\_





## REDDING DERMATOLOGY MEDICAL GROUP, INC.

### HIPAA NOTICE OF PRIVACY PRACTICES

This Notice describes how we may use and disclose your protected health information (PHI), including any substance use disorder (SUD) records we create, receive, or maintain. It also describes your rights and our legal duties. "Protected Health Information" (PHI) is information about you, including demographic details, that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services.

#### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may use and disclose your PHI for Treatment, Payment, and Health Care Operations (TPO) without your authorization, as permitted or required by law. Examples include:

- **Treatment:** Sharing information with other providers involved in your care.
- **Payment:** Billing your insurance and obtaining reimbursement.
- **Health Care Operations:** Quality improvement, training, and business activities.

We may also use or disclose PHI without authorization in situations required or permitted by law (e.g., public health reporting, abuse/neglect, law enforcement, coroners, research, workers' compensation).

**Special Rules for Substance Use Disorder (SUD) Records (42 CFR Part 2)** If we receive or maintain records protected under 42 CFR Part 2 ("Part 2 records" or SUD treatment records from a federally assisted SUD program), additional strict protections apply. These records generally require your specific written consent for most uses and disclosures, including for treatment, payment, or health care operations in many cases. A single consent can cover multiple future TPO disclosures.

**Important Limitation on Use in Legal Proceedings:** SUD treatment records received from programs subject to 42 CFR Part 2, or testimony relaying the content of such records, shall **not** be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent or a court issues an order after notice and an opportunity for you (or the record holder) to be heard, as provided in 42 CFR Part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the record is used or disclosed.

We will only use or disclose Part 2 records as permitted by law. You may revoke consent (in writing) at any time, except to the extent action has already been taken in reliance on it.

#### YOUR RIGHTS

You have the right to:

- Inspect and copy your PHI (with limited exceptions, such as psychotherapy notes or information compiled for legal proceedings).
- Request restrictions on certain uses/disclosures (we are not required to agree, except in limited cases for payment or health care operations when you pay out-of-pocket in full).
- Request confidential communications by alternative means or at alternative locations.
- Request an amendment if you believe information is incorrect or incomplete.
- Receive an accounting of certain disclosures.
- Obtain a paper copy of this Notice at any time.
- File a complaint with us or the Secretary of the U.S. Department of Health and Human Services if you believe your privacy rights have been violated. We will not retaliate against you.

#### CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and this Notice. We will post the revised Notice and make it available upon request. Material changes will be posted prominently.

#### COMPLAINTS

Contact our HIPAA Compliance Officer to file a complaint or ask questions. You may also complain to the U.S. Department of Health and Human Services, Office for Civil Rights.

#### EFFECTIVE

This Notice became effective on April 14, 2003, and was revised in January 2026 to address updated requirements for SUD records.

#### ACKNOWLEDGMENT OF RECEIPT

Signature below acknowledges that you have received this Notice of Privacy Practices.

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SIGNATURE OF PATIENT/RESPONSIBLE PARTY

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DATE



## REDDING DERMATOLOGY MEDICAL GROUP, INC.

### ACKNOWLEDGMENT OF PRACTICE POLICIES FINANCIAL AND TREATMENT AGREEMENT

**REGISTRATION AND INSURANCE:** All patients must fully and accurately complete our patient information forms and keep all information current. You must present a current, valid insurance card and government-issued photo ID at the time of service. We participate in Medicare assignment and most major insurance plans. **You are solely responsible** for verifying your own insurance coverage, benefits, and obtaining any required referrals or prior authorizations. Failure to provide correct or updated insurance information may result in you being personally responsible for the entire balance.

**INSURANCE BILLING AUTHORIZATION AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:**

I hereby authorize Redding Dermatology Medical Group, Inc. to furnish any and all information necessary, including medical records, chart notes, biopsy/lab results, and billing information, to my insurance company or third-party payer for the purpose of obtaining reimbursement for services rendered.

I assign and transfer to Redding Dermatology Medical Group, Inc., all rights to medical benefits payable for services provided to me. I direct my insurance company to pay benefits directly to Redding Dermatology Medical Group, Inc.

I understand and agree that **I am personally and fully financially responsible** for all charges for services rendered, including but not limited to copayments, deductibles, coinsurance, non-covered services, denied claims, and any balances not paid by insurance within ninety (90) days of the billing date. I assume full responsibility for any charges if my insurance carrier elects not to pay within ninety (90) days. **Copayments, deductibles, and any estimated patient responsibility amounts are due at the time of service. If you cannot pay at the time of service, your appointment will be rescheduled.**

**UNINSURED, COSMETIC, OR SELF-PAY PATIENTS:** Full payment is due at the time of service with no exceptions.

**MISSED APPOINTMENT / CANCELLATION POLICY:** We require at least twenty-four (24) hours' advance notice (or one full business day, whichever is longer) to cancel or reschedule an appointment without incurring a fee. Patients arriving more than fifteen (15) minutes after their scheduled appointment time may be rescheduled at the provider's sole discretion.

- First missed appointment without timely cancellation: **\$25.00 fee**
- Each subsequent missed appointment: **\$50.00 fee**

These fees apply uniformly to **all** patients, including Medicare beneficiaries (as permitted by CMS guidelines). The fees are your personal responsibility and must be paid in full before any future appointments can be scheduled. We will consider documented emergencies on a case-by-case basis. No-show or cancellation fees do not apply to Medi-Cal/Medicaid patients where prohibited by state law.

**SCHEDULED SURGERIES OR PROCEDURES:** If a surgery or procedure is scheduled, your account will be forwarded to a surgery coordinator for insurance eligibility verification, benefit determination, and a written good-faith cost estimate of your financial responsibility. A pre-surgical deposit equal to your estimated patient responsibility (based on deductible, coinsurance, and non-covered amounts) may be required prior to the procedure. Cancellation less than twenty-four (24) hours prior to the scheduled time or failure to appear will result in a **\$50.00 fee**, which must be paid before any future scheduling.

**BILLING AND PAYMENTS:** Monthly statements will be sent. Payment is due upon receipt. Acceptable payment methods include our patient portal, our text-to-pay service, mail, by calling our billing office at (530) 241-7098, or in person at any office location. We offer autopay for balances under \$10.00. Payment plans may be considered on a case-by-case basis.

**MINORS:** A parent or legal guardian must accompany any patient under the age of 18 for the initial visit and is fully responsible for payment of all charges. Minors may attend subsequent appointments unaccompanied only if they are able to settle any outstanding balance due at that time.

**TREATMENT AUTHORIZATION:** By agreeing to receive care, I authorize Craig A. Kraffert, M.D., and/or his chosen associates, assistants, and staff to perform the recommended dermatologic procedure(s) and any additional or alternative procedures that, in the provider's professional medical judgment, may be reasonably necessary or advisable during the course of treatment. This authorization includes (but is not limited to) the selection and administration of anesthesia, performance of pathology services, and proper disposal of any severed tissue in accordance with standard medical practice. I understand that all medical procedures involve risks, including but not limited to infection, bleeding, scarring, pigmentation changes, allergic reactions, anesthesia complications, and, in rare cases, serious injury or death. No warranty or guarantee has been made to me as to the results or cure of any condition.

**MEDICAL DEBT PROTECTIONS:** We do not report medical debt to any consumer credit reporting agencies in California or Oregon.

California-Specific Notice: A holder of this medical debt contract is prohibited (by Section 1785.27 of the Civil Code) from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable. Upon request, we will make reasonable efforts to financially assist eligible patients before initiating collection actions.

**NOTICE TO CONSUMERS:** Medical doctors and their associates are licensed and regulated by the Medical Board of California and the Oregon Medical Board. The Medical Board of California can be reached by phone: (800) 633-2322 or on their website: [www.mbc.ca.gov](http://www.mbc.ca.gov). The Oregon Medical Board can be reached by phone: (877) 254-6263 or on their website: [www.oregon.gov/omb](http://www.oregon.gov/omb). To check a license or file a complaint regarding a physician, these resources are available to all patients. The Open Payments Database ([openpaymentsdata.cms.gov](http://openpaymentsdata.cms.gov)) is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. This database is available to the public.

**FULL AGREEMENT:** I have carefully read, fully understand, and voluntarily agree to all terms and conditions stated above. I acknowledge that this agreement is binding and enforceable to the fullest extent permitted by law in California and Oregon.

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SIGNATURE OF PATIENT/RESPONSIBLE PARTY

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DATE