DERMATOLOGY OF NORTHERN COLORADO

Part of Advanced Dermatology & Cosmetic Surgery

PATIENT INFORMATION:

DATE: _____

NAME: _____
Last First MI Preferred Name

BIRTHDATE: ____/____/____ AGE: _____ SSN: _____ SEX: M_____F_____

RACE: ☐ White ☐ American Indian ☐ Black or African American ☐ Asian ☐Other_____
ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

ADDRESS: _____
Street Address Unit Number City State Zip Code

PHONE: (HOME) _____ (CELL) _____

E-MAIL ADDRESS: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

PRIMARY CARE PHYSICIAN: _____

INSURANCE POLICY HOLDER: _____
Name Date of Birth Relationship

EMERGENCY CONTACT: _____
Name Phone # Relationship

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS:

Unless you object, our office may contact you via email, letter, phone call and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. By providing the practice with your e-mail address and cellular phone number, you are agreeing to be contacted by e-mail and/or text message. We will leave a detailed message on your answering machine or voice mail, unless you instruct us otherwise. You must notify us in writing of your objections to be reminded of an appointment or to leave detailed messages on your voice mail or answering machine. You may opt out from receiving contact by e-mail or text appointment at any time by writing to the Privacy Officer, ADCS Clinics, LLC, Inc., 151 Southhall Lane, Suite 300, Maitland, FL 32751.

PRIVACY POLICY NOTICE:

I acknowledge that I understand the privacy policies mandated by the Health Insurance Portability and Accountability Act (HIPAA) that went into effect April 14, 2003.

FINANCIAL AGREEMENT & INSURANCE AUTHORIZATION:

I request that payment of authorized Medicare / Medigap or other insurance benefits be made on my behalf to the Dermatology of Northern Colorado, P.C. for any services furnished to me by either physician / supplier. I authorize Dermatology of Northern Colorado, P.C. to release to the Health Care Financing Administration and its agents or my insurance company any information needed to determine these benefits payable for related services. **I understand that I am responsible for understanding my insurance coverage. I understand that prior authorization of services does not necessarily guarantee payment. I understand that I am responsible for any deductibles, coinsurance, co-pays and services deemed not medically necessary by my insurance carrier.**

BY SIGNING BELOW, PATIENT/GUARDIAN UNDERSTANDS THE TEXT OR EMAIL CONSENT FOR REMINDERS AND OTHER HEALTH CARE COMMUNICATIONS, THE TERMS OF OUR PRIVACY POLICY NOTICE AND FINANCIAL AGREEMENT & INSURANCE AUTHORIZATION.

_____ _____
Patient signature (OR Parent/Guardian signature if patient is a minor) Date

MEDICAL INFORMATION

Name: _____ Preferred Name: _____

Preferred Pharmacy and Location: _____

Reason for today's visit: _____

Past Medical History (Please check all that apply):

- ☐ None
- ☐ Anxiety
- ☐ Arthritis (which type?) _____
- ☐ Asthma
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Thyroid Disorder (type?) _____
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Pacemaker
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Other _____

Past Surgical History (Please check all that apply)

- ☐ None
- ☐ Heart: Coronary Artery Bypass
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Heart Transplant
- ☐ Joint Replacement: Which? _____
- ☐ Kidney Transplant
- ☐ Spleen Removed
- ☐ Uterus Removed

Other _____

Skin Disease History (Please check all that apply)

- ☐ None
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer

Other _____

Yes	No	
☐	☐	Do you wear sunscreen?
☐	☐	Do you tan in a tanning bed?
☐	☐	Do you have a family history of melanoma? If yes, which relative? _____

Review of Systems

Yes	No		Yes	No	
☐	☐	Problems with bleeding	☐	☐	Problems with scarring (hypertrophic or keloid)
☐	☐	Problems with healing	☐	☐	Immunosuppression

Medications: (Please include dosages and frequency of use)

_____

_____

_____

Allergies: (Please enter all allergies)

_____

_____

_____

Social History: (Please check all that apply)

- ☐ Current Smoker
- ☐ Former Smoker
- ☐ Never Smoked
- ☐ Never Drink Alcohol
- ☐ Occasionally Drink Alcohol
- ☐ Drink Alcohol Daily

Occupation: _____

Employer: _____

PERMISSION TO RELEASE MEDICAL AND BILLING INFORMAITON:

Dermatology of Northern Colorado has my permission to leave personal medical information and billing information in the following locations in the event that I cannot be reached directly:

PLEASE INITIAL YOUR RESPONSE BELOW: (DO NOT ✖ or✓)

Are we able to leave messages on the Home Voicemail? (Please initial)

- YES _____
- NO _____
- I DON'T HAVE A HOME PHONE _____

PLEASE INITIAL YOUR RESPONSE BELOW: (DO NOT ✖ or✓)

Are we able to leave messages on the Cell Phone Voicemail? (Please initial)

- YES _____
- NO _____
- I DON'T HAVE A CELL PHONE_____

I authorize the following friend or relative to discuss my medical/billing information:

What is the relationship to this person? (Please check one)

- ○ Spouse/significant other
- ○ Parent(s)/guardian(s)
  - (Please include both names if applicable)
- ○ Adult Child
- ○ Friend
- ○ I DO NOT WANT TO AUTHORIZE ANY PERSON TO DISCUSS MY INFORMATION

Name(s): _____

_____

Phone Number(s): _____

_____

_____ _____

Print patient name **Date of birth**

_____ _____

Patient signature **Today's date**

_____ _____

Parent/Guardian signature if patient is a minor **Relationship to patient**

PATIENT REFERRAL SOURCE:

How did you hear about our practice? (Please check all that apply)

- ○ Another Physician/Provider: _____
- ○ Insurance Company: _____
- ○ Other – Please list: _____
- ○ Internet/Web Search
- ○ Friend or Family member

WRITTEN ACKNOWLEDGEMNET FORM
RECIEPT OF NOTICEOF PRIVACY PRACTICES
Revised August 1, 2017

I, _____, have (1) received a copy of the Notice of the Privacy Practices OR
Please Print Name
(2) have been offered a copy of the Notice of Privacy Practices but declined to accept a copy.

_____ _____
Signature of Patient Date

**We keep copies of the Notice of Privacy Practices at the front desk, if you would like one for your reference at any time, please ask.

Office Use Only Please:

Written Acknowledgement of Patient Refusal to Sign for Receipt of Notice of Privacy Practices

On the _____ day of _____, _____, the Notice of Privacy Practices was offered and/or given to

_____.
Patient Name

_____ The patient accepted a copy of the Notice of Privacy Practices but refused to sign and acknowledge that it was given to the patient.

_____ The patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

_____ _____
Signature of Employee that offered the patient the Notice
Date

FINANCIAL POLICY ADDENDUM 2018

It is the responsibility of all patients/guarantors to understand their insurance. Please be advised that many procedures performed in this office may apply to your annual deductible or may require additional out-of-pocket expenses beyond your co-pay (i.e. Co-insurance). **Tests and treatments performed in our office are necessary to ensure proper diagnosis and care for our patients.**

All biopsies and mole removals performed in this office will be submitted to pathology for analysis. Biopsies are an example of a procedure that could be subject to a deductible or co-insurance. **In the event that special stains are required for pathology, there will be additional lab fees submitted to your insurance. Once that claim has been processed you will receive a statement if there is any remaining patient responsibility. For our self-pay patients, you will receive a statement for the additional testing that was performed. Please be aware that additional copays are also required by many insurance companies for pathology.**

Other examples include:

- Liquid nitrogen for the destruction of lesions such as warts or pre-cancerous lesions (classified as surgery by all insurance companies)
- All excisions including removal of skin cancer and atypical moles
- Injections (considered a procedure by all insurance companies)
- Photodynamic Therapy
- PUVA/UVB light box treatment

It is important for our patients to be aware that a covered benefit does not mean it will be paid for if your annual deductible or out of pocket maximum has not been satisfied.

All costs for services rendered are calculated at check- out. This is an ***estimate*** based on our contract with your insurance carrier. Payment is due at check-out unless prior payment arrangements have been made. Because these are ***estimates only,*** the final cost for services may be higher or lower after the claim has been adjudicated by your insurance carrier. You will be billed for any additional costs after adjudication or refunded if the fees are less than estimated. **Please note; statements are not mailed for balances under $10.00. These balances will be collected at your next visit.**

Failure to cancel an appointment at least 24 hours prior to the scheduled appointment will be subject to a fee of $50 for surgical appointments/ $25 for all other scheduled visits including aesthetics.

We accept several forms of payment for your convenience:

- Visa, MasterCard, Discover and Care Credit
- Checks, money orders or cash

I have read and understand the above.

Patient signature: _____ Date: _____

Print patient name: _____

Parent/Guardian signature if patient is a minor: _____