



Date: _____

Nickname: _____

Date of Birth: _____ Birth Sex: _____ SSN (if Medicare/Tricare): _____

Mailing address: _____

City, State, Zip Code: _____

Cell: _____ Home: _____ Work: _____

OK to leave a detailed message? YES NO Preferred phone: HOME WORK CELL

Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Marital Status: _____ Occupation/Employer: _____

Race (optional): _____ Ethnicity (optional): _____

Primary Care Physician (PCP): _____ Phone: _____

Referring Physician Name (if not PCP): _____ Phone: _____

Insurance Information:

Primary Insurance: _____

Secondary Insurance: _____

Responsible Party Information (complete only if different than above):

Name: _____ Date of Birth: _____

Mailing Address: _____

City, State, Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

By signing this authorization, I verify the accuracy of my demographic information. I also authorize Colorado Dermatology Specialists to share my protected health information (PHI) with the providers I have listed on this form.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: (Please circle one) SELF GUARDIAN POWER OF ATTORNEY



History and Intake Form

Name: _____ DOB: _____

Past Medical History: (please circle all that apply)

- | | |
|------------------------------|----------------------------|
| Anxiety disorder | Elevated blood pressure |
| Arthritis | End Stage Renal Disease |
| Asthma | Epilepsy |
| Atrial fibrillation | GERD |
| Benign prostatic hyperplasia | Hypertension |
| Breast cancer | Hearing Loss |
| Cerebrovascular accident | HIV/AIDS |
| Colon cancer | High Cholesterol |
| COPD | Hyper- or hypo- thyroidism |

Other: _____

Past Surgical History:

NONE

Other:

Skin Disease History: (please circle all that apply)

- | | | |
|-------------------------|-----------------|----------------------------|
| Acne | Dysplastic mole | Pruritus (itch) of scalp |
| Actinic keratoses | Eczema | Psoriasis |
| Asteatosis cutis | H/O asthma | Squamous cell skin cancer |
| Basal cell skin cancer | H/O hay fever | Sunburn of a second degree |
| Contact with poison ivy | Melanoma | NONE |

Other: _____

Do you wear sunscreen? Yes No If yes, what SPF? _____

Do you use tanning beds? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____



Preferred Pharmacy: _____
Location/Phone Number: _____

Medications: (please enter all current medications)

DRUG ALLERGIES: _____

Social History: (please circle all that apply)

Cigarette Smoking:

- Currently smokes
- Former smoker
- Never smoked

Alcohol Use:

- EtOH – None
- EtOH – less than 1 drink per day
- EtOH – 1-2 drinks per day
- EtOH – 3 or more drinks per day

Review of Systems: (please circle all that apply)

- | | | |
|---------------------------|---------------------------|---------------------|
| Pregnancy or planning one | Unintentional weight loss | Joint aches |
| Problems with bleeding | Sore throat | Headaches |
| Problems with healing | Blurry vision | Shortness of breath |
| Immunosuppression | Abdominal pain | Anxiety |
| Fever or chills | Bloody urine | Depression |

Alerts: (please circle all that apply)

- | | | |
|--------------------------------|------------------------------|-----------------------------------|
| Allergy to adhesive | Artificial heart valve | Defibrillator |
| Allergy to lidocaine | Artificial joint replacement | Rapid heart beat with epinephrine |
| Allergy to topical antibiotics | Blood thinners | NONE |

Quality Measures:

Patients aged 12-20:
Tobacco use? Yes No

Patients aged 65+
Have you received a pneumonia vaccination? Yes No
Do you have a health care proxy? Yes No
Do you have a living will? Yes No
Which statement reflects your wishes on advanced care?
1. Do not intubate
2. Do not resuscitate
3. Full cardiopulmonary Resuscitation



PATIENT FINANCIAL POLICY & PATIENT RESPONSIBILITY NOTICE

Thank you for choosing Colorado Dermatology Specialists for your skin care needs. We are committed to providing you with the highest quality care. A copy of this policy will be provided to you upon request.

Charges incurred for services rendered are the patient's responsibility regardless of insurance coverage. Your insurance coverage is a contract between you and your insurance company, not your insurance company and us.

Colorado Dermatology Specialists provides many different types of medical services within our practice. Many insurance carriers have their own specific criteria set for how frequently an exam, test or procedure can be performed in addition to not paying for certain types of services such as routine/screening testing i.e. blood work, removal of certain skin conditions, etc. Therefore, Colorado Dermatology Specialists will not be responsible for knowing your insurance coverage.

For those insurances with whom we participate, we will file a claim on your behalf directly to the insurance carrier for payment. You are responsible for all copays, coinsurance, deductibles, and non-covered services. We are obliged to collect your copay at the time of service per your insurance company. We accept cash, debit card, check, MasterCard & Visa.

INSURANCE: If you are insured with a plan we are not contracted with, payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your coverage. It is advised that you call and confirm with your insurance carrier that we are contracted with your insurance plan. Please understand that we cannot waive deductibles, coinsurances or copays that are required by your insurance. This is a violation of insurance rules and can be punishable as fraud. Our fees are representative of the usual and customary charges for our area.

IT IS YOUR RESPONSIBILITY:

1. To be familiar with your insurance coverage, benefits and rules.
2. To notify our office of any insurance changes prior to the time of the visit.
3. To bring your insurance card(s) and photo ID to each visit.
4. To obtain a referral from your PCP if your insurance plans require one. If you do not have the required referral, you may either be required to pay the full fee at the time of your visit or reschedule your visit.
5. To be prepared to pay all copayments, coinsurance and deductibles according to your insurance plan at the time of your visit.

IDENTIFICATION: All patients must complete our patient information forms before seeing a provider. We will obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the claim.

NON-INSURED PATIENTS: Patients who are not covered by an insurance plan are responsible for services rendered at the time of service. For those patients who are unable to pay for service in full, a minimum of 50% of the charges are due at the time of service. Payment for any remaining balance is payable within 30 days of the date of service.



MINOR PATIENTS: For all services provided to a minor patient, we will look to the adult accompanying the patient and the parent or guardian with custody for payment. The accompanying adults must provide a photo identification and consent to treatment.

NONPAYMENT: If your insurance company does not pay your claim in 45 days as required by Colorado State Law, the balance will automatically be billed to you. If your account is over 30 days past due after the insurance company has paid their portion and a statement has been sent out, partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and you may be discharged from this practice. In the event of finding it necessary to turn your unpaid balance over to a collection agency, all collection fees and/or legal fees will be owed in addition to the remaining balance. If this occurs, you will be notified by regular or certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physicians will only be able to treat you on an emergency basis.

CONSENT TO TREAT: This consent provides us with your permission to treatment at this office, as requested by you, or diagnosed by your physician. This consent will remain fully effective until it is revoked in writing. You have the right to discuss the purpose, potential risks and benefits of any treatment or procedure. If you have any concerns about any treatment or procedure, we encourage you to ask questions prior to treatment. **Your consent to treatment acknowledges that you understand and agree to the procedure and our billing for any/all services rendered.** I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

ADDITIONAL PRACTICE RELATED FEES AND POLICIES

- \$25 Fee “No Shows” (Failure to provide cancellation notice 24 hours prior to your scheduled appointment).
- \$25 Fee Request to complete Life, Disability, FMLA & many other various types of independent health forms. Please allow 3-5 days for completion of such forms.
- \$40 Fee Returned checks for nonsufficient funds, which is a charged back processing fee to the patient. We will be unable to accept any personal check until account balance and associated service fees are paid in full. If this is a repeated occurrence, we will only be able to accept cash or credit card as method of payment.
- Other Biopsy, Pathology and Lab samples sent to labs outside of our office are billed independently of Colorado Dermatology Specialists. You may receive a bill from the outside lab and will be responsible for payment to that facility.

ACKNOWLEDGEMENT: I have read and agree to abide by the financial policy of Colorado Dermatology Specialists. Any questions I have were answered to my satisfaction. **I understand that this office will submit a claim to insurance for ANY and ALL services rendered during my appointment per this consent.**

Patient/Guardian Print Name

Patient/Guardian Signature

Today's Date



Patient Privacy Policy Notice
Effective: September 1st, 2019

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing (including text and email), to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.
-

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.



Patient Privacy Policy Notice
Effective Date: September 1st, 2019

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstance, except as required under HIPAA. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 1st, 2019 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer at 303-850-9715 for more information, in person or in writing. All requests related to release or evaluation of PHI must be made in writing and addressed to the Practice Compliance Officer.



Privacy Policy Acknowledgement
Effective Date: September 1st, 2019

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I am a patient of Colorado Dermatology Specialists. I hereby acknowledge receipt of Colorado Dermatology Specialists' Notice of Privacy Practices.

Name (please print): _____ Date of Birth: _____
Signature: _____ Date: _____

OR

I am a parent or legal guardian of _____
[patient name/date of birth]

I hereby acknowledge receipt of Colorado Dermatology Specialists' Notice of Privacy Practices with respect to the patient.

Name (please print): _____
Relationship to Patient: Parent Legal Guardian
Signature: _____ Date: _____

DOCUMENTATION OF GOOD FAITH EFFORTS (for use by staff only when acknowledgement cannot be obtained from the patient)

The patient presented to the office on _____ and was provided with a copy of Colorado Dermatology Specialists' Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- Patient refused to sign
- Patient was unable to sign or initial because: _____
- The patient had a medical emergency, and an attempt to obtain the acknowledgement will be made at next available opportunity.
- Other reason (describe) _____

Signature of Employee Completing Form: _____ Date: _____