Date: _____

Patient Information

Legal Name: _____ 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
Arthritis
Asthma
Atrial fibrillation
Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
High Blood Pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other: _____

Past Surgical History:

NONE

Other:

_____
_____
_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
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
NONE

Other: _____

Do you wear Sunscreen? Yes No If yes, what SPF? _____
Do you have a history of tanning bed use? Yes No
Do you still 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)

_____
_____
_____
_____

Social History: (please circle all that apply)

Cigarette Smoking:	**Alcohol Use:**
Currently Smokes	EtOH – None
Has smoked in the past	EtOH – less than 1 drink per day
Never smoked	EtOH – 1-2 drinks per day
Former smoker	EtOH – 3 or more drinks per day

Other:

_____
_____

Review of Systems: (please circle all that apply)

Problems with bleeding	Unintentional weight loss	Neck stiffness
Problems with healing	Thyroid problems	Headaches
Problems with scarring	Sore throat	Seizures
Rash	Blurry vision	Cough
Immunosuppression	Abdominal pain	Shortness of breath
Hay fever	Bloody stool	Wheezing
Chest pain	Bloody urine	Anxiety
Fever or chills	Joint aches	Depression
Night sweats	Muscle weakness	**NONE**

Other: _____

Alerts: (please circle all that apply)

Allergy to adhesive	Blood thinners	Rapid heartbeat with epinephrine
Allergy to lidocaine	Defibrillator	Currently pregnant or trying?
Allergy to topical antibiotics	MRSA	History of HIV/AIDS
Artificial heart valve	Pacemaker	Hepatitis C
Artificial joint replacement	Require antibiotics prior to surgery	**NONE**

Drug Allergies: _____

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

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.

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 if 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.

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: _____