Southern Colorado Dermatology Clinic, P.C.

PATIENT INFORMATION

Date:_____ Primary Care Physician:_____

Email Address:_____

Name: Last_____First_____MI_____

Address:_____City_____State_____Zip_____

Phone:_____-_____-_____ Date of Birth_____Female ☐ Male ☐

Social Security #_____-_____-_____ Marital Status: S M D W Race:_____

NAME OF CONTACT FOR EMERGENCY NOTIFICATION: _____Phone:_____-_____-_____

How did you hear about us? _____ Family Member _____Friend _____ Physician _____Website _____Phone Book

PRIMARY INSURANCE INFORMATION

(THIS SECTION MUST BE COMPLETED EVEN THOUGH WE HAVE SCANNED YOUR INFORMATION)

Name of Primary Insurance Company:_____

Member ID#_____ Group#_____

Are you the Policy Holder? Yes ☐ No ☐ If "NO" please complete information below

Policy Holder Last Name:_____ First Name:_____

Address:_____City_____State_____Zip_____

Policy Holder Date of Birth:_____Relationship to patient_____i.e self, spouse, parent, child

SECONDARY INSURANCE INFORMATION

DO YOU HAVE A SECONDARY INSURANCE? Yes ☐ If "YES" PLEASE COMPLETE INFORMATION BELOW No ☐

Name of Secondary Insurance Company:_____

Member ID#_____ Group#_____

Are you the Policy Holder? Yes ☐ No ☐ If "NO" please complete information below

Policy Holder Last Name_____ Policy Holder First Name_____

Date of Birth:_____Relationship to patient_____i.e self, spouse, parent, child

Southern Colorado Dermatology Clinic, P.C.

Name:_____ Date of Birth_____

Primary Care Physician:_____ Referring Physician:_____

Brief Reason for your Visit (including location, duration and symptoms): _____

_____

_____

How has it been treated? _____

History of Other Skin Conditions: _____

_____

Topical Medications: _____

Family History of Skin Diseases: _____

Have you ever fainted during a Medical Procedure? _____ YES _____ NO

List of medications, including non-prescription(s) Herbs & Vitamins: _____

_____

Name of Pharmacy: _____

Drug Allergies: Penicillin YES OR NO Drug Reaction: Hives/Rash Anaphylactic Nausea/Vomiting

Codeine YES OR NO Drug Reaction: Hives/Rash Anaphylactic Nausea/Vomiting

Aspirin YES OR NO Drug Reaction: Hives/Rash Anaphylactic Nausea/Vomiting

Other:_____ Other:_____

Asthma	YES	NO	Tuberculosis	YES	NO	Joint Pain	YES	NO
Pace Maker	YES	NO	Stomach/Bowl Disease	YES	NO	Taking Oral Contraceptives	YES	NO
Diabetes	YES	NO	Lupus	YES	NO	Taking Hormone Replacements	YES	NO
Heart Disease	YES	NO	Kidney/Bladder Disease	YES	NO	Currently Breast Feeding	YES	NO
High Blood Pressure	YES	NO	Lung Disease	YES	NO	Are you Pregnant	YES	NO
Keloids/Scarring	YES	NO	Liver Disease	YES	NO	Seizures	YES	NO
Melanoma	YES	NO	Hepatitis	YES	NO	Artificial Joints	YES	NO
Previous Efudex/Carac	YES	NO	Cold Sores/Herpes	YES	NO	Thyroid Disease	YES	NO
Psoriasis/Eczema	YES	NO	HIV	YES	NO	Rheumatoid Arthritis	YES	NO
Radiation Therapy	YES	NO	Canker Sores	YES	NO	Endocrine Disease	YES	NO
Skin Cancer	YES	NO	Heart Murmur	YES	NO	Hay Fever	YES	NO

Other Medical Problems: _____

Tobacco Use: _____Currently _____Former _____Never

Do you Exercise? _____YES _____NO What is your Occupation? _____

SOUTHERN COLORADO DERMATOLOGY CLINIC, P.C.

Health Insurance Portability and Accountability Act (HIPAA)

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

If you would like a copy of our privacy notice, please ask our receptionist.

I, _____, acknowledge receiving and reading a complete copy of the Notice of Privacy Practices for Southern Colorado Dermatology Clinic, P.C. on this _____ day of _____, 20_____. I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices.

_____ _____

Printed Name of Patient Signature of Patient

Patient authorizes communication with the following. Please list below with whom we may speak with regarding your medical care and their relationship to you.

_____ _____ _____

Name Relationship Phone Number

_____ _____ _____

Name Relationship Phone Number

MESSAGES:

Leave a message on Patients' home and/or cell phone?

_____ Allowed _____ Not Allowed Home #_____ Cell #_____

Leave a message with the person who answers the Patients' home and/or cell phone?

_____ Allowed _____ Not Allowed

Contact patient at work and tell them who is calling if asked? Work #_____

_____ Allowed _____ Not Allowed

Leave a message on Patients' work phone?

_____ Allowed _____ Not Allowed Work #_____

Southern Colorado Dermatology Clinic, P.C.
Financial Policies (effective 1-1-20)

Welcome to our office! We are pleased that you have chosen us for your dermatological care. We would like to inform you of our payment policies. We accept, cash, personal checks, Visa, MasterCard, Discover, and American Express.

Contracted Insurance Companies: If you have medical insurance that Southern Colorado Dermatology Clinic is contracted with, we will submit your insurance claims for you, providing we have the correct identification card. You are responsible for any applicable copays which are due at the time of service. You are also responsible for any amounts not covered by your insurance company, including deductible and coinsurance. If your coverage is denied for ANY reason, you are responsible for the entire balance due. We WILL NOT be responsible for any payment denials made on claims by your insurance carrier due to incorrect identification information, benefit denials or any service deemed not medically necessary, cosmetic determinations or for any other services not deemed a benefit of your insurance benefit plan. It is your responsibility to know and understand your benefit coverage. By signing below, you agree to be responsible for any costs incurred for services at our facility and agree that all insurance payments be made directly to Southern Colorado Dermatology Clinic, P.C.

Non-Contracted Insurance Companies: As a courtesy we will bill the insurance company, however, payment is expected at the time of service.

Self-Pay: If you have no medical insurance, payment is expected at the time of service.

Biopsies: All biopsies done in this office will be sent to an outside Pathology Lab. You may receive a separate bill from the pathology company, depending on your insurance coverage. Our office is not responsible for their billing. If you should have any questions, you will need to contact them directly.

Referrals/Authorizations: If your insurance requires a referral or authorization for an appointment or a procedure you are responsible to contact your primary care physician and/or insurance for the approval before your appointment. If we do not have the referral at the time of your visit, you may be asked to reschedule your appointment.

Request for additional procedure(s): During your appointment, if additional procedures are requested, an office visit may apply.

Returned Checks: If your check is returned for insufficient funds, a **$25.00** fee will be assessed to your account. You will need to provide within 15 days another type of payment (i.e. cashier check, credit card or cash).

Delinquent Account: In the event your account becomes delinquent, you are responsible for the charges incurred, but also any costs involved in collections of your account. These include, but are not limited to, interest charges, re-billing fees, court costs, attorney fees and collection costs. If your account is assigned to a Collection Agency, you agree to pay costs of collections of **35%**. In addition, you agree to pay all court costs and reasonable attorney fees. Insurance coverage is a matter between your insurance company and yourself; and ultimately you are responsible for the payment of your account.

Authorization to Release Information: I authorize and direct my insurance companies including private insurance, and other health/medical plans to issue payment directly to Southern Colorado Dermatology Clinic, PC for services rendered for me or my dependents. I hereby authorize Southern Colorado Dermatology Clinic, PC to release any information acquired in the course of examination or treatment needed to determine benefits or the benefits payable for related services. I will be fully responsible for any and all charges incurred in the course of treatment.

Signature of Patient/Guardian:_____ **Date:**_____