Accent Dermatology and Laser Institute, PLLC

Patient Information: (This section refers to **PATIENT ONLY**, please **PRINT**) **Date:** _____

Patient Name (Legal): _____
Last First M.I. (Nickname)

Birth Date: _____ Age: _____ Gender: _____ Social Security #: _____

Mailing Address: _____
Street/PO Box City State Zip Code

Do you give permission for Accent Dermatology and Laser Institute Staff to leave **detailed messages at your preferred contact number** regarding any tests that you may incur as a patient, including but not limited to; biopsy results, blood/ lab results, or other test results? **Yes** **No** **(Please Circle your preferred phone number)**

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

E-Mail Address: _____

☐ I would like to receive emails for Product/ Procedure Specials and Newsletters. *(About once a month)*

Marital Status: Single / Married / Separated / Divorced / Widowed/ Annulled/ Common Law/ Domestic Partner

Employer/School: _____ Your Job Title: _____ Industry: _____

***Please answer questions 1-3, by CIRCLING your response OR filling in the 'Other' line.**

1. **Race:** White / African-American / American Indian/ Alaska Native / Native Hawaiian/ Other Pacific Islander/ Asian
   Other: _____ OR **Decline to Specify**
2. **Ethnic Group:** **Are you…** Hispanic or Latino / **Not** Hispanic or Latino / Unknown / **Decline to Specify**
3. **Preferred Language:** English / Spanish / **Other:** _____

Policy Holder / Responsible Party Information: (*If different from patient*)

Name: _____ Relationship: _____ Birth Date: _____

Social Security Number: _____ Employer: _____ Phone: _____

Referral Information: (Please circle the appropriate selection below to help us determine how you were referred to our office.)

Physician Friend Relative One of our patients Name: _____

Insurance Phone Book Internet Church Bulletin Other: _____

Emergency Contact Information: (In case of emergency, who should be notified?)

Name _____ Relationship _____ Phone _____

Contact Information:

Do you give our office permission to discuss your medical information with **family members OR Friends**, including but not limited to: biopsy results, blood/ lab results, or other test results? **Yes** **No** **If yes**, please provide their name and number below.

Name: _____ Relationship: _____ Phone #: _____

Social History:

What **state/country** were you born in? _____ Where did you grow up? _____

# of Children: _____ # of Grandchildren: _____# of Siblings:_____

Hobbies? _____

Primary Care Physician: _____ **Phone #:** _____

Referring Physician: _____ **Phone #:** _____

Pharmacy Information:

Please choose a local and/or mail order pharmacy. This can be changed at any time. **We will have your local pharmacy as your preferred pharmacy unless otherwise requested.**

Preferred Pharmacies: (Name, Location (City), Phone #, and/or Cross Streets, etc.)

Local Pharmacy: _____

Mail Order Pharmacy: _____

Family History: (Please indicate with a check (√), relatives with any of the following conditions:

Medical Condition	Mom	Dad	Daughter(s)	Son(s)	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Alcoholism										
Allergy/ Hayfever										
Arthritis										
Asthma										
Cancer, Breast										
Cancer, Colon										
Cancer, Lung										
Cancer, Ovary										
Cancer, Prostate										
Skin Cancer, Melanoma										
Skin Cancer, Squamous Cell Carcinoma										
Skin Cancer, Basal Cell Carcinoma										
Depression										
Diabetes										
Eczema										
Heart Disease										
High Cholesterol										
High Blood Pressure										
Kidney Disease										
Parkinson's Disease										
Stroke										
Thyroid Disorder										
Other medical illnesses										
Other skin diseases										

Accent Dermatology and Laser Institute, PLLC

Patient Health Summary (Please DO NOT skip any questions. Print only)

Date: _____

Patient's Name (Legal): _____ **Date of Birth:** _____

Allergies:

Do you have any Allergies and/or Sensitivities/ Adverse Reactions? *(Medications, Foods, Topical Antibiotics, Adhesives, Bandages, Lidocaine, Topical antibiotic Ointments and/or Environmental)*:

_____

_____

☐ **No Known** Allergies/ Drug Allergies

Medication:

List all medications you are currently taking (prescriptions (INCLUDING BLOOD THINNERS), over-the-counter medications (INCLUDING ASPIRIN), **vitamins, supplements & herbals**.) If you have a list that you would like photo copied, please hand it to the receptionist and check this box. ☐ **SEE LIST**

☐ **I'M NOT TAKING ANY PRESCRIPTIONS, OVER-THE-COUNTERS OR HERBALS**

1. **Medication**/Vitamin Name: _____

   Dosage: _____ How Often taken: _____

2. **Medication**/Vitamin Name: _____

   Dosage: _____ How Often taken: _____

3. **Medication**/Vitamin Name: _____

   Dosage: _____ How Often taken: _____

4. **Medication**/Vitamin Name: _____

   Dosage: _____ How Often taken: _____

5. **Medication**/Vitamin Name: _____

   Dosage: _____ How Often taken: _____

6. **Medication**/Vitamin Name: _____

   Dosage: _____ How Often taken: _____

PAST SURGICAL HISTORY: (e.g. C-Section, Tonsillectomy, Appendectomy, Wisdom Teeth Removal, etc.)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

-See Other Side-

Accent Dermatology and Laser Institute, PLLC

Patient Health Summary (Please DO NOT skip any questions. Print only)

Have you been previously diagnosed with any of the following? Please indicate any medical problems not listed below in the "Other" box.

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ BPH (Enlarged Prostate)
- ☐ Bone Marrow Transplant
- ☐ Cancer: What kind? _____
- ☐ COPD
- ☐ Coronary Heart Disease
- ☐ Cystic Ovaries / PCOS
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Valve Replacement
- ☐ Hepatitis (A, B, or C)
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Joint Replacement: Where? _____
- ☐ Migraines/ Headaches
- ☐ Osteopenia
- ☐ Radiation Treatment
- ☐ Renal Disease (Stage: _____)
- ☐ Seizures
- ☐ Stroke
- ☐ Other: _____

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Atypical Moles
- ☐ Basal Cell Carcinoma *
- ☐ Blistering Sunburn
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaky/ Itchy Scalp
- ☐ Hay Fever/ Allergies
- ☐ Melanoma *
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Squamous Cell Carcinoma *
- ☐ Other: _____ _____ _____

Do you use sunscreen <u>daily</u>? Yes / No ***If Yes,*** *what SPF:* _____

Have you <u>EVER</u> used a tanning bed? Yes / No Are you ***Currently*** *using one?* ***Yes / No***

Do you drink alcohol? Yes / No **How often:** *Less than 1 drink a day 1-2 Drinks/Day 3+/Day*

Do you smoke: Tobacco / Chewing Tobacco? (Never / Former / Current) **Quantity per day:** _____

Do you use recreational drugs? Yes / No ***If Yes,*** *What and how often?* _____

Were you ever a Life Guard? Yes / No ***If Yes,*** *how long?* _____

OFFICE POLICY AND PROCEDURE

OFFICE HOURS: *Mon-Thurs - 8:00 AM -5:00 PM, Fridays - 8:00 AM -4:00 PM *Excluding Holidays**
We CLOSE early on SOME TUESDAYS and every THURSDAY, from 11:00 AM -2:00 PM.

Dear Patient:

We appreciate your confidence in choosing Accent Dermatology and Laser Institute, PLLC for your skin care needs. Please take a moment to review our financial policy so that you understand your responsibility regarding the charges for the services rendered to you by this office. We require you to **read and sign our electronic version of this document prior to receiving treatment. This copy is for you to keep.**

When asked, and as a courtesy to you, we will try to give you general guidelines about what your insurance policy might cover. Since medical insurance is an agreement entered into by you and your insurance carrier, you are ultimately responsible for knowing the specifics of what your policy covers and for notifying us when your insurance changes. Failure to update us with changes in your insurance coverage may result in a denial of coverage from your carrier, and in that case, you would be responsible for payment of the entire amount due. Payment is due at the time of service. Acceptable forms of payment are cash, check, VISA, MasterCard and Discover.

IF YOU ARE *A **SELF PAYING PATIENT*** – AT CHECK-IN WE WILL ASK YOU TO ALLOW US TO TAKE A COPY OF YOUR DRIVER'S LICENSE AND A BLANK CHECK OR COPY OF YOUR CREDIT CARD PRIOR TO YOUR VISIT WITH THE PHYSICIAN. THIS WILL BE USED AT CHECK-OUT.

If we participate (i.e. are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for the charges that relate to **COVERED** services rendered. **This means that services for the removal of benign lesions, which are not likely covered by insurances (for example: skin tags, seborrheic keratosis, telangiectasiae, leg veins, and other COSMETIC procedures), will be paid at the time of service.** We will bill both your primary and secondary insurance plans for covered services under the contracted plans. Complete insurance information, including referrals from other providers, for primary and secondary insurance coverage(s) must be made available to the Practice including all identification, benefits cards/documents, and any other information required by your insurance carrier, for accurate filing of claims. In the event that we are not aware of a charge that is not covered by your plan, you will be billed the balance after we obtain the denial from your insurance. **You are responsible AT THE TIME OF SERVICE for payment of: co-payments, and/or charges for non-covered or cosmetic services.**

ABOUT CO-PAYMENTS: If you are an enrollee of a managed care plan (HMO or PPO) that we are contracted with, you are required to **pay the co-payment each time you are seen, (including follow-up appointments)** and it must be paid before you see the physician. If you are not prepared to pay the co-payment, the visit must be rescheduled. If you do not know your co-payment, we will collect $25.00 for your co-payment at check-in.

ABOUT REFERRALS: If you are enrolled in an HMO or other plan which requires a referral from your primary care physician, you must have the referral with you OR the referral must have been sent to us in advance of your visit in order to be seen by the physician. **You are responsible for obtaining your own referral (from your primary care physician), FOR EVERY VISIT.**

OFFICE POLICY AND PROCEDURE

Medicare Patients: **We are Medicare participating providers**. We will bill Medicare and the Medigap carriers. You will be responsible at the time of service for co-payments and charges for non-covered or cosmetic services.

***YOU WILL BE ASKED TO SIGN A WAIVER OF LIABILITY FORM KNOWN AS AN ABN (ADVANCED BENEFICIARY NOTICE) IN THE EVENT THAT A SERVICE IS PROVIDED WHICH WE KNOW IS NOT, OR HAVE REASON TO BELIEVE MAY NOT BE COVERED BY MEDICARE.**

If you have Medicare as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill, and **you** will be responsible for the balance.

For non-Medicare patients: If you have insurance coverage with an insurance carrier with which we have no contractual relationship, please note the following: **you are responsible, at the time of service, for payment of all services.** You will receive forms at the time of service which you can use to bill your primary and secondary insurance plans for any reimbursement that may be due from you under your policy. **Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits.**

Cancellation Policy: We recognize that everyone's time is valuable, so we make every effort to maintain the scheduled appointment times. If you arrive more than 10 minutes late for your scheduled appointment you may be asked to reschedule.
THIS TIME IS RESERVED EXCLUSIVELY FOR YOU. WE REQUEST THAT YOU ALLOW ONE HOUR TO BE IN OUR OFFICE. **BEGINNING JANUARY 2017, WE WILL CHARGE $35.00 FOR EVERY MISSED MEDICAL APPOINTMENT / APPOINTMENT CANCELED WITHOUT 24 HOURS' ADVANCE NOTICE. AFTER ANY COMBINATION OF 3 MISSED APPOINTMENTS / APPOINTMENTS CANCELED WITHOUT 24 HOURS' ADVANCE NOTICE, YOU WILL BE DISCHARGED FROM THE PRACTICE UNLESS THERE ARE EXTENUATING CIRCUMSTANCES.**

Cosmetic Cancellation Policy: Should you need to cancel or change the date of your procedure, we require at least **24 HOURS NOTICE** as a courtesy to other patients seeking our services. Any procedure canceled without 24 hours notice will incur a **$100.00 CANCELLATION FEE**. A credit card number may be required to hold your reservation.

Rx Refills: Please contact your pharmacy for any refill requests; they will electronically contact the office for approval. Allow up to 48 business hours for refills to be completed. Refills received after 3:00 PM on Friday will be considered part of Monday's business.

Surescripts: By signing this form, you are giving Accent Dermatology permission to access your insurance prescription formulary through surescripts. This lets us see what medications are on your insurance company's formulary, and it helps us determine which medications are covered by your insurance policy.

Divorce Situations: We look to the adult who has brought the child in for the appointment to be responsible for payment of the services which are rendered to the child. We expect the parents to be able to work out payment arrangements with one another. Our office staff will not participate in any disputes which may arise with respect to financial liability or responsibility.

This is your copy to keep. Please see our receptionist to sign the electronic copy of this form.

HIPAA PRIVACY NOTICE

- This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
- At Accent Dermatology and Laser Institute, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by your primary care doctor or a specialist whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- If you have paid for services "out of pocket", in full, 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 may use or disclose your health information for our normal health care operations. For example, one of our staff may enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information.
- We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. Please contact us to update your account, so we can keep you informed.
- You have the right to transfer copies of your health information to another practice. We will mail or fax your files for you.

HIPAA PRIVACY NOTICE

- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, ACCENT DERMATOLOGY AND LASER INSTITUTE, 400 Indiana St. Suite 390, Red Rocks Medical Center, Golden, Colorado 80401. Tel: (303) 463-9600.
- This notice goes into effect as of April 14th, 2013.

This is your copy to keep. Please see our receptionist to sign the electronic copy of this form.