MOUNTAINTOP DERMATOLOGY

Minor Patient Information

MINOR'S INFORMATION: (TO BE FILLED OUT BY CUSTODIAL PARENT OR LEGAL GUARDIAN)

Last Name: _____First Name: _____MI: _____

Goes By (If Different Than Above):_____ DOB: _____ Sex: ☐ M ☐ F

Ethnicity/Race: _____ Preferred Language: _____

CUSTODIAL PARENT OR LEGAL GUARDIAN INFORMATION:

Last Name: _____First Name: _____ DOB: _____

Address: _____Apartment # _____

City: _____State:_____ Zip Code: _____

Home Phone: _____Cell: _____ Work: _____

Email Address: _____

MINOR'S INSURANCE INFORMATION:

Primary Insurance		**Secondary Insurance**	
Insurance Name:	_____	Insurance Name:	_____
Subscriber ID:	_____	Subscriber ID:	_____
Group ID:	_____	Group ID:	_____
Policy Holder Name:	_____	Policy Holder Name:	_____
Relationship to Patient:	_____	Relationship to Patient:	_____
Policy Holder's Date of Birth:	_____	Policy Holder's Date of Birth:	_____
Policy Holder's SS#:	_____	Policy Holder's SS#:	_____

PAYMENT POLICY: It is the policy of this office that the adult presenting the child for treatment must be a Custodial Parent or Legal Guardian. As the patient's Custodial Parent or Legal Guardian you will be held responsible for payment of the copayment at the time of service as well as any charges deemed payable by the insurance company. You are also liable to provide us with correct and current insurance information and/or any changes in names or addresses. We will not participate in any disputes between divorced parents and will not forward bills to other parties regardless of court rulings or divorce decrees. Incorrect information, resulting in the denial or delay of claims will result in the Custodial Parent or Legal Guardian being liable for all charges. We will hold the Custodial Parent or Legal Guardian financially responsible for all charges, including collections costs, which are not covered by the insurance company.

ACKNOWLEDGEMENT: By signing this authorization, I accept and acknowledge the accuracy of all information provided.

_____ _____

Custodial Parent or Legal Guardian Signature **Date**

Name of Primary Care Physician: _____

Address: _____ City, State, Zip: _____

Office Phone #:_____ Office Fax #: _____

Name of Referring Physician (if different from above):_____

Address: _____ City, State, Zip: _____

Office Phone #:_____ Office Fax #: _____

Name of any other Physician you want us to share your visit notes with: _____

Address: _____ City, State, Zip: _____

Office Phone #:_____ Office Fax #: _____

Please initial if you **DO NOT** want Mountaintop Dermatology to share information pertaining to your care with your primary care or referring healthcare provider. **_____ Initial**

How did you hear about Mountaintop Dermatology?

☐ Internet search ☐ Dex phonebook ☐ Tri-Lakes phonebook ☐ Insurance provider website
☐ Building sign ☐ Referral from patient
☐ Other: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have, or have been given the opportunity, to read in full and obtain my own copy of the **Notice of Privacy Practices** from Mountaintop Dermatology as required by government statute.

NOTICE OF CONSENT FOR TREATMENT & FINANCIAL POLICY

I acknowledge that I have, or have been given the opportunity, to read in full and obtain my own copy of the **Financial Policy Statement** from Mountaintop Dermatology and I agree that I am financially responsible for all services rendered. If I am covered by an insurance company that requires a referral from my primary care physician, it is my responsibility to obtain that referral authorization prior to my appointment.

PAYMENT AUTHORIZATION

I authorize payment of all insurance benefits, if any, to be made directly to Mountaintop Dermatology for all services rendered. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement is as valid as the original.

ACKNOWLEDGEMENT: By signing this authorization, I acknowledge the accuracy of all information provided.

_____ _____

Patient or Legal Guardian Signature **Date**

***** Minors MUST have a Parent/Legal Guardian present for their initial office visit. If you would like to give your consent for the unaccompanied follow up treatment or your 16 or 17 year old, or if you would like to designate an authorized adult to accompany your minor, you must fill out a Consent Form for Treatment of a Minor.

MOUNTAINTOP DERMATOLOGY

Medical History Form

Last Name: _____First Name: _____MI:_____

Date of Birth: (MM/DD/YY) _____Today's Date: _____

Preferred Pharmacy: _____

Cross Streets: _____

Reason for today's visit? _____

Past Medical History:

Have you been previously diagnosed with any of the following?

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ (Irregular Heartbeat)
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ None

List any other past or present diseases or conditions: _____

List any surgical procedures you have had in the last 24 months: _____

_____

Skin Disease History:

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer
- ☐ None

Other: _____

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

Do you tan in a tanning salon? ☐ Yes ☐ No

Family History:

Do you have a family history of Melanoma? ☐ Yes ☐ No ☐ Unknown

If yes, which relative? _____

Medications:

List all medications you are currently taking (including prescriptions, over the counter medications, vitamins and herbals):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies: Are you allergic to any medications? ☐ Yes ☐ No If yes, list below:

_____ _____ _____

Social History:

What is your smoking status? Never Former Current Everyday Someday

Do you use IV drugs? ☐ Yes ☐ No If yes what? _____ How often?_____

Do you drink alcohol? ☐ Yes ☐ No If yes how many per day? _____

What is your occupation? _____What are your hobbies?_____

Review of Systems:

Do you develop Keloid (raised) scars after surgery?	☐ Yes	☐ No	☐ Not Sure
Do you have problems with healing?	☐ Yes	☐ No	☐ Not Sure
Do you bleed easily?	☐ Yes	☐ No	☐ Not Sure

Have you been previously diagnosed with any of the following?

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Pacemaker
- ☐ Artificial heart valve
- ☐ Artificial joints (within last 2 years)
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ None

Have you had a reaction to local anesthesia (Lidocaine) at a dermatology or dental visit? ☐ Yes ☐ No

Have you ever experienced light headedness or dizziness during a medical procedure? ☐ Yes ☐ No

Women:

Could you be pregnant? ☐ Yes ☐ No Are you trying to become pregnant? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Do you get yeast infections with antibiotic use? ☐ Yes ☐ No

MOUNTAINTOP DERMATOLOGY

Consent for Treatment
&
Financial Policy Statement

CONSENT FOR TREATMENT:
By signing this form, I authorize Mountaintop Dermatology and its personnel to provide ongoing medical care, treatment and procedures (skin biopsies, routine surgical procedures etc.) as ordered by the physician and/or other health care providers. I acknowledge that no guarantee can or will be made as to the results of the care, treatment and medication prescribed.

TREATMENT FOR MINORS:
We appreciate that you have entrusted us to provide health care services to your minor child. In order to ensure proper consent for treatment minors must have a Parent/Legal Guardian present for their initial office visit. If you would like to give your consent for the unaccompanied follow up treatment or your 16 or 17 year old, or if you would like to designate an authorized adult to accompany your minor, you must fill out a Consent Form for Treatment of a Minor. Thank you, we look forward to working with you to ensure that your child receives the very best health care possible.

INSURANCE PARTICIPATION:
As a service to our patients we will file claims to the companies we are contracted with for the services provided. It is the patient's responsibility to ensure that the physician he/she is seeing is listed with their insurance company as a participating provider. Any patient treated by a non-participating physician will be responsible for any deductibles, co-insurance, uncovered services, etc., imposed by their insurance company.

PATIENT RESPONSIBILITY:
- Verify with your insurance carrier that the services performed or proposed by our office are covered under your individual plan. We suggest you contact the customer service telephone number listed on your insurance card prior to being seen in our office.
- Since your agreement with your insurance carrier is a private one, it is your responsibility to know what your policy covers and what it does not. We cannot quote your benefits. Any disputes about payment must be resolved between you and your insurance company.
- Obtain any authorizations or referrals required by your insurance carrier.
- Pay our office for any co-payment and any unpaid portion of the deductible at the time of service. Any additional co-payments, deductibles and/or co-insurance will be billed to the patient as indicated by your insurance carrier on their Explanation of Benefits (EOB).
- All patients without insurance must pay in full at the time services are rendered. *Please ask about our discounted rate for self-pay patients.

RELEASE OF ASSIGNMENT:
I hereby give authorization for payment of all insurance benefits to be made directly to Mountaintop Dermatology for services rendered. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits.

_____ **Initial**

DENIED CLAIMS:
Ultimately, you are responsible for the full charges for your visit. Our billing agent will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, pre-existing conditions or any other matter, which causes the claim to be denied. Should your claim be denied for any of these reasons or any other reasons not listed here, the claim will become the responsibility of the patient and full payment will be expected immediately.

LABORATORY CHARGES:
Many times it may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. If a biopsy or other lab work is done, there is a separate fee for processing and interpretation of the biopsy and/or lab work. **This means that you will receive a separate bill from another doctor or laboratory for these tests**. We will attempt to use a lab which files directly with your insurance carrier. Although the lab will file with your insurance, you are responsible for any bill you may receive from the laboratory or pathology services used. If you receive a bill from the lab, please contact the lab directly at 303-493-7700 to resolve any billing concerns.

PAYMENT OPTIONS:
For your convenience we offer a variety of payment options. We accept Visa, Master Card, American Express, Discover Card, Personal Checks, Cashier/Bank Checks and Cash. All returned checks will be assessed a $30.00 returned check fee in addition to the original charge.

ACCOUNT BALANCES/COLLECTIONS:
I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default (unpaid balance 90 days from date of treatment) I understand my account will be assessed a minimum $25.00 transfer fee, or 35% of balance owed whichever is greater, and your account may be forwarded to an outside collection agency. I agree to pay all costs of collection including but not limited to interest, rebilling fees, court costs, attorney fees and collection agency costs.

APPOINTMENT POLICY:
We understand that unplanned issues can come up and you may need to cancel an appointment, however, when a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. If you need to cancel or reschedule your appointment you must let us know at least 1 full business day before your appointment. A $25 fee will be assessed for no shows or cancellations with less than 1 full business days' notice. Mountaintop Dermatology reserves the right to dismiss patients from the practice for violating this policy. Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

ACKNOWLEDGEMENT:
I acknowledge that I have read and understand Mountaintop Dermatology's Consent for Treatment & Financial Policy Statement and I agree to be bound by its terms. I also understand and agree that such terms may be amended by Mountaintop Dermatology at any time.

_____ _____

Patient Signature or Legal Guardian, if a minor* **Date**

MOUNTAINTOP DERMATOLOGY

Consent Form for Treatment of a Minor

Patient Name:_____ Date of Birth:____/____/____

Many times Parents/Legal guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your teen or young adult children.

Children 16 or 17 Years Old:

Minors MUST have a Parent/Legal guardian present for initial office visit or they will be asked to reschedule their appointment. If the patient is 16 or 17 years old, they can be seen for follow up appointments without a Parent/Legal guardian only if Parent/Legal guardian fills out and signs this consent form authorizing Mountaintop Dermatology to provide treatment to their teen.

I hereby grant Mountaintop Dermatology permission to treat my 16 or 17 year old teen when they arrive at the office unaccompanied:

_____ ____/____/____

Signature of Parent/Legal Guardian Date

Children 15 Years Old or Younger:

Minors 15 years old and younger MUST have an adult present for all office visits or they will be asked to reschedule their appointment. If the patient is 15 years old or younger, they will be able to be seen for their appointment with an adult present other than a Parent/Legal guardian only if Parent/Legal guardian fills out and signs this consent form authorizing Mountaintop Dermatology to provide treatment to their child.

I hereby grant Mountaintop Dermatology permission to treat my child when they arrive at the office accompanied by the authorized named adult listed below.

_____ _____

Name of Authorized Adult Relationship to Patient

_____ ____/____/____

Signature of Parent/Legal Guardian Date

Copay amounts will be due at the time of visit. Please ensure that the patient and/or patient's guardian is equipped to pay the copay amount designated by your insurance company.