



New Patient Information

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Preferred Name (If different than above): _____ DOB: _____ Sex: M F

Address: _____ Apartment # _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

What is the first/best number you would like us to try to reach you? Home Cell Work

Email Address: _____ Employer Name: _____

Ethnicity/Race: _____ Preferred Language: _____

IN CASE OF EMERGENCY: (PLEASE NOTIFY)

Name: _____ Phone: _____

Relationship to Patient: _____

May we discuss your medical information with this person? Yes No

PATIENT INSURANCE INFORMATION:

Primary Insurance

Insurance Name: _____

Subscriber ID: _____

Group ID: _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's SS#: _____

Secondary Insurance

Insurance Name: _____

Subscriber ID: _____

Group ID: _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's SS#: _____

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 Signature

Date

* Minors **MUST** have a Parent/Legal Guardian fill out a separate information form. 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.



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 | Coronary Artery Disease | Hyperthyroidism |
| Arthritis | Depression | Hypothyroidism |
| Asthma | Diabetes | Leukemia |
| Atrial Fibrillation
(Irregular Heartbeat) | End Stage Renal Disease | Lung Cancer |
| Bone Marrow Transplant | GERD | Lymphoma |
| BPH | Hearing Loss | Prostate Cancer |
| Breast Cancer | Hepatitis A B C | Radiation Treatment |
| Colon Cancer | Hypertension | Seizures |
| COPD | HIV/AIDS | Stroke |
| | Hypercholesterolemia | 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 | Flaking or Itchy Scalp |
| Actinic Keratosis | Melanoma |
| Asthma | Precancerous Moles |
| Basal Cell Skin Cancer | Psoriasis |
| Blistering Sunburns | Squamous cell skin cancer |
| Dry Skin | None |
| Eczema | |

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



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