OFFICE USE ONLY

NextGen MRN#: EMA MRN#:

Name:
Date of Birth:

ACKNOWLEDGEMENT OF OFFICE POLICIES

Please review and sign after reading each policy listed below

General Patient Authorization: I hereby authorize providers of Center for Dermatology & Plastic Surgery to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice.

____**Receipt of Notice of Privacy Practices:** Center for Dermatology & Plastic Surgery's Notice of Privacy Practices provides information about how Center for Dermatology & Plastic Surgery may use and disclose protected health information about me. The Notice of Privacy Practices contains a Patient Rights section describing my rights under the law. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices of Center for Dermatology & Plastic Surgery. Center for Dermatology & Plastic Surgery reserves the right to change the Notice of Privacy Practices.

_____**Cancellation Policy:** If a patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Center for Dermatology & Plastic Surgery reserves the right to charge a $50 fee if a patient does not cancel his/her appointment within 24 hours or a loss of a deposit if a patient does not cancel a surgical appointment within 24 hours. Administrative fees incurred for failure to provide cancellation notice are not billable to insurance or any other third party payor. These policies include appointments with all providers and estheticians.

Release of Medical Information:

I do / do not (*circle one*) authorize Center for Dermatology & Plastic Surgery and its designated representatives to release my medical information to my primary care physician. If authorized, please provide name of physician: _____.

If at any time you should need a copy of your medical records, we require a written release to be signed and dated. The form is available at our front desk and can be requested by email. Please allow up to 15 business days to complete your request. If your request is urgent, please mark the request as urgent and someone from our staff will contact you to expedite your request. Absent providing a secure fax number, records must be MAILED to your address of record. Copies of blood work and pathology reports are provided at no charge, copies of your complete medical record or office notes will require $25 fee.

Center for Dermatology & Plastic Surgery requires awritten records release form to transmit records to any physician or medical organization that is not listed as your referring physician. If you have a consulting physician you would like to have listed as an authorized recipient of your medical information, please request and complete a release form for each physician you wish to receive your records.

Contact Permission: In the event that Center for Dermatology & Plastic Surgery needs to contact you (the patient), regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Yes **No** (*circle one*) Leave a message on an answering machine/voicemail system.

Yes **No** (*circle one*) Speak with other authorized individuals listed below.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Yes **No** (*circle one*) Send a text message to the following number: _____

_____**Expiration of and Right to Revoke Authorization to Disclose Protected Health Information:** I understand that I can withdraw my permission set forth above at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Release of Medical Information" and "Contact Permission". I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

The duration of this authorization is valid until the earlier to occur of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the following specific date (optional): *Month:*_____ *Day:*_____ *Year:* _____.

_____**Physician Assistant, Nurse Practitioner, & Esthetician Information:** Center for Dermatology & Plastic Surgery may staff physician assistants, nurse practitioners, and estheticians to assist in the delivery of medical dermatology care. A physician assistant ("PA") is not a doctor but is a graduate of a certified training program and is licensed by the Arizona Regulatory Board of Physician Assistants. Under the supervision of a physician, a PA can diagnose, treat, and monitor common acute and chronic diseases. Supervision does not require the constant physical presence of a supervising physician, but rather overseeing their work. In collaboration with a physician, nurse practitioners can diagnose, treat, and monitor common acute and chronic diseases. Estheticians provide services as directed by a PA, nurse practitioner or physician. I understand that at any time I can request to see a physician. I have read the above and hereby consent to the services of a PA, nurse practitioner, or esthetician for my health care needs.

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Date of Birth:

ACKNOWLEDGEMENT OF OFFICE POLICIES

Unaccompanied Minors (Under 18 Years Old): New patients who are minors must have a parent or legal guardian present for the new patient visit. Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. Should you wish for us to see your teen/young adult child when they arrive at the office unaccompanied please read, indicate and sign below:

YES NO (*circle one*) I hereby grant the physicians and providers at Center for Dermatology & Plastic Surgery permission to treat my child when they arrive at the office unaccompanied. I understand this may include changes in current therapy my child is receiving including treatments or minor skin surgery.

Signature: _____ Date: _____

_____**Proof of Identity:** Center for Dermatology & Plastic Surgery requires proof of identity on file. I understand that I will be asked to provide a photo ID such as a driver's license at check-in. This will be scanned into your private medical record as a means to document who we are treating.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

_____ _____
Signature of Patient or Guardian Date

_____
Relationship

OFFICE USE ONLY	
NextGen MRN#:	EMA MRN#:

Name:
Date of Birth:

FINANCIAL POLICY NOTICE

Thank you for choosing Center for Dermatology & Plastic Surgery. Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit please contact our billing department as soon as possible. We strongly encourage each patient to contact their insurer directly prior to receiving services to ensure that they fully understand their benefits and coverage. We accept cash, checks, MasterCard, Visa, Discover, American Express and CareCredit.

Please review and sign after reading each policy listed below

_____**Private Pay (Self-Pay):** I understand that if I do not have health insurance, full payment is due at the time of service.

_____**Policy Benefits / Non-Covered Charges:** I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Center for Dermatology & Plastic Surgery of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect my coverage. I understand that I am responsible for any amounts not covered by my insurer. Routine in-office procedures, including but not limited to, biopsies, injections, destruction of precancerous and non-cancerous growths and surgical removal and repair of cancerous and non-cancerous growths and Mohs surgery are billed separately from my office visit and may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance companies may require for payment.

_____**Copayments:** I understand that all copays are due at the time of my appointment and before I see the provider. Given that Center for Dermatology & Plastic Surgery physicians are specialists, a higher copay may be required.

_____**Deductibles:** I understand that if it is determined that my insurance policy has an unmet deductible, payment for services at the contracted rate between DCenter for Dermatology & Plastic Surgery and my insurer will be due at the time of service.

_____**Managed Care (HMO) Plans or Health Select:** I understand it is my responsibility to obtain any and all necessary referrals including referrals for follow up visits if my plan requires one. Center for Dermatology & Plastic Surgery will strive to keep me informed of visits remaining on a referral and/or the expiration date but it is ultimately my responsibility to know this information and to make the necessary arrangements through my primary care physician. I understand that failure to obtain a referral, if required by my insurance for coverage, will result in me bearing complete financial responsibility for any and all services received.

_____**Benefit Representation:** I understand that the staff of Center for Dermatology & Plastic Surgery will make every effort to accurately verify my insurance benefits but I will not solely rely on this preliminary verification as a basis for making financial decisions regarding treatment. I understand that I have a right to refuse any and all services before they are rendered if I think they are non-covered services or non-payable by my insurance. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them.

_____**Assignment of Benefits:** I understand I must provide a copy of my current insurance card in order to file an insurance claim. I assign directly to the providers at Center for Dermatology & Plastic Surgery all insurance benefits, if any, otherwise payable to me for services rendered. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance or Medicare. I further agree to pay for any items or services not covered by insurance or Medicare, as applicable. I hereby authorize the Center for Dermatology & Plastic Surgery to release all information necessary to secure all payments or approvals of benefits.

_____**Payment for Ancillary Services (Laboratory/Pathology):** I understand that Center for Dermatology & Plastic Surgery utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures) and blood chemistry. These laboratories will bill for services separately from Center for Dermatology & Plastic Surgery. I acknowledge that payments made to Center for Dermatology & Plastic Surgery are for services rendered by Center for Dermatology & Plastic Surgery and authorize the use of outside laboratories as deemed necessary and warranted by my doctor(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

_____**Worker's Compensation:** I understand that Center for Dermatology & Plastic Surgery does not accept Worker's Compensation cases.

_____**Returned Checks:** I understand that checks presented to Center for Dermatology & Plastic Surgery as payment for services rendered and subsequently returned by my bank for any reason as unpaid will be charged a returned check fee of $25. Balances must be handled by cash, credit card or money order. Center for Dermatology & Plastic Surgery reserves the right to represent returned checks electronically for their face value plus the returned check fee.

_____**Past Due Accounts:** I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter. I acknowledge that I must contact Center for Dermatology & Plastic Surgery before this time if I wish to make other payment arrangements.

_____**Credit Card on File:** By my signature below I am enrolling in Automatic Payments, I authorize and request that my service provider Center for Dermatology & Plastic Surgery ("Service Provider") charge the debit or credit card I have designated or electronically debit my bank account for a payment by me of up to $200.00 upon determination of my balance by Service Provider. "Service Provider" means Center for Dermatology & Plastic Surgery and all its affiliated and related organizations. This authorization applies to each charge by Service Provider to me for balances effective after the date of this authorization that is less than or equal to $200.00.

OFFICE USE ONLY	
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IMPORTANT: If paying for healthcare services rendered, the following consent applies. The following does not apply to the payment of health insurance premiums.

This authorization applies separately to each of Service Provider's patient accounts billed to me and the balances that I owe under each of those patient accounts. A patient account is a financial obligation as a result of a visit to enter for Dermatology and Plastic Surgery. I understand that a Service Provider may create multiple patient accounts for me as a result of a single visit to Service Provider, and that multiple patient accounts may be listed on a single statement I receive in the mail. For example, a single radiology service visit may result in one statement mailed to me with two patient accounts and charges of up to $200.00 against each patient account under this authorization: one charge of up to $200.00 for the facility usage and another charge of up to $200.00 for a radiologist to interpret the test.

This authorization is in effect until I terminate it. In addition, this authorization will terminate automatically if my Service Provider ceases to do business with its current payment processor, InstaMed, or for the reason described below. I understand that I have the right to terminate or modify this authorization, including updating my payment method, or discontinuing automatic payments by notifying my Service Provider in writing to 14275 N 87th St, Ste 110, Scottsdale, AZ 85260. I understand that the termination of this authorization in no way relieves me of the obligation to fulfill my obligations to my Service Provider. My request to terminate this authorization must be received at least two (2) business days before my next payment.

If your payment is declined for any reason, including due to incorrect card or bank account information, expired information or insufficient funds, your payment will not be processed and this authorization will be terminated. I understand that if my payment is not processed I am still obligated to pay the applicable amount to my Service Provider.

I authorize my debit / credit card issuer and / or financial institution (bank) to honor transactions processed by this authorization. I certify that I am an owner of or authorized signer for the debit / credit card or the designated bank account. I acknowledge that a transaction involving a debit from my bank account is subject to the Rules and Operating Guidelines of NACHA and charge to my card is subject to the card brand rules and any agreement between me and my card issuer.

I understand that I should read this authorization carefully and keep a copy for my records. To receive a copy of this authorization for no charge I may contact my Service Provider at the address or phone number provided above.

I can change my contact information by contacting my Service Provider using the information provided above.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

Signature of Patient or Guardian/Guarantor **Date**

Relationship

CENTER FOR
Dermatology &
Plastic Surgery

Today's Date:
EMA MRN:

MEDICAL HISTORY

Name: _____ DOB:

Primary Care Physician / Contact: _____
Referring Physician (if different): _____

Birth Sex: ☐ Male ☐ Female Preferred gender: ☐ Male ☐ Female ☐ Other: _____

Preferred language: _____ Race/Ethnicity: _____

Preferred pharmacy (please include name, address, cross streets or phone number):
_____

How did you hear about us? (PCP, Friend, Insurance, Other): _____

Reason for visit (*separate visit may be required):

☐ Acne ☐ Upper body skin exam ☐ *Hair Loss
☐ Psoriasis ☐ Total body skin exam ☐ *Cosmetic Concerns
☐ Spot(s) of concern ☐ *Rash
☐ Other: _____

Skin Disease History: ☐ **NONE**

☐ Acne ☐ Actinic keratoses (pre-cancers) ☐ Blistering sunburns
☐ Eczema ☐ Basal cell carcinoma ☐ Seborrheic dermatitis
☐ Psoriasis ☐ Squamous cell carcinoma ☐ Atypical/dysplastic moles
☐ Psoriatic Arthritis ☐ Melanoma
☐ Allergic contact dermatitis (Cause?): _____
☐ Other: _____

Do you wear sunscreen? ☐ Yes ☐ No SPF? _____

Have you ever used a tanning bed? ☐ Yes ☐ No
Currently? ☐ Yes ☐ No
Total number of lifetime tanning sessions: _____

EMA MRN:

Past Medical History: ☐ **NONE**

☐ Atrial Fibrillation
☐ Coronary Artery or Heart Disease
☐ Heart attack or stents
☐ High Blood Pressure
☐ High Cholesterol
☐ Asthma
☐ COPD
☐ Diabetes
☐ End Stage Renal Disease
☐ GERD (reflux / heart burn)
☐ Anxiety
☐ Depression
☐ Leukemia
☐ Lymphoma
☐ Glaucoma
☐ Hearing Loss
☐ Herpes or Cold Sores
☐ HIV/AIDS
☐ Seizures
☐ Stroke
☐ Anemia
☐ Thyroid problems (hyper or hypothyroidism)
☐ Arthritis (joint pain): Type: _____
☐ Hepatitis: Type: _____ Treatment: _____
☐ Bone Marrow Transplantation
☐ History of Tuberculosis
☐ Solid Organ Transplantation: Organ: _____ Year: _____
☐ Immunosuppression: _____
☐ Cancer (other than skin): Type: _____ Year: _____
☐ Lupus or other autoimmune disease: Type: _____

Past Surgical History: ☐ **NONE**

☐ Skin Cancer Surgery: _____
☐ Cosmetic Procedures: _____
☐ Joint Replacement: Joint: _____ Year: _____
Do you take antibiotics before going to the dentist? ☐ Yes ☐ No
☐ Cancer Surgery (other than skin): _____
☐ Heart Surgery (including pacemaker or other implant): _____
☐ Heart Valve Replacement: Valve: _____ Type: _____ Year: _____
☐ Lung/Abdomen Surgery: _____
☐ Other: _____

Family History (indicate relative & disease): ☐ **NONE**

☐ Melanoma: _____
☐ Skin cancer (non-melanoma): _____
☐ Psoriasis: _____
☐ Other skin disease: _____
☐ Other serious family illnesses: _____

EMA MRN:

Social History:

Occupation: _____ Are you married? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Decline to Answer

Do you currently use contraception? ☐ Yes ☐ No If yes, type? _____

Women: Currently pregnant or trying? ☐ Yes ☐ No Currently breastfeeding? ☐ Yes ☐ No

Medications: Please list **each medication** (including over the counter and supplements) with **the dosage.**
You may attach a pre-printed list if you prefer. ☐ **NONE**

_____

_____

_____

_____

_____

_____

Allergies: ☐ **NONE**

Medication Allergies: Please list **each medication** (including over the counter) and **the reaction.**

_____

_____

Seasonal or Environmental Allergies: ☐ Yes ☐ No If yes, to what? _____

Are you currently experiencing any of the following?

☐ Fever
☐ Chills
☐ Night Sweats
☐ Unintentional weight loss
☐ Headache
☐ Weakness
☐ Numbness
☐ Bleeding problems
☐ Easy Bruising
☐ Joint aches
☐ Sore throat
☐ Cough
☐ Chest Pain: Severity? _____
☐ Shortness of breath: Severity?_____
☐ Blood in urine
☐ Blood in stool
☐ Nausea / Vomiting
☐ Abdominal cramps or pain
☐ Blurry vision

EMA MRN:

_____

Signature of Patient or Patient's Legal Guardian

CENTER FOR
Dermatology &
Plastic Surgery

Patient name: DOB:
Today's Date:

Patient Demographics
E-mail Address

Itch Factor
If presenting today for a rash, how severe is your itch? 0 1 2 3 4 5 6 7 8 9 10 (no itch) (worst itching)

Social History
Smoking Status (12 years and older) Never smoker , Former Smoker , Current every day smoker
Alcohol Status Yes No

Social History
Smoking Status (12 years and older) Never smoker , Former Smoker , Current every day smoker
Alcohol Status Yes No

Will/Advanced Care (65 years and older)
Power of Attorney
Name of Power of Attorney
Power of Attorney Number
Advanced Directives Care Planning • Living Will (Care Plan) • Do Not Resuscitate • Do Not Intubate • Full Cardiac Resuscitation • None

Signature of Patient or Patient's Legal Guardian Today's Date

CENTER FOR
Dermatology &
Plastic Surgery

PATIENT INFORMATION

Appointment Date:

MRN #:

Patient Name: **Nickname:**

SSN: **DOB:** **Marital Status:** **Gender:**

Primary Address:(for billing and other correspondence)
Secondary Address:

City: **State:** **Zip:**

Race: ☐ White/Caucasian ☐ American Indian ☐ Asian ☐ Black/African American ☐ Other_____

Language: ☐ English ☐ Other_____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

WHEN CENTER FOR DERMATOLOGY AND PLASTIC SURGERY HAS TO CALL:

PLEASE NOTE: ALL numbers listed below are subject to phone or text confirmation for upcoming appointments and post-appointment surveys

What number do you want called **1st:** _____ ☐ Home ☐ Cell ☐ Work ☐ Other_____

What number do you want called **2nd:** _____ ☐ Home ☐ Cell ☐ Work ☐ Other_____

PLEASE NOTE: The numbers listed above are also subject to messages from our office

Primary Care Physician (PCP):
(Please list physicians first and last name- NOT facility) **Phone Number:**

Referring Physician (If any):
(Please list physicians first and last name- NOT facility) **Phone Number:**

What email address do you want to use for appointment confirmations, post-appointment surveys, newsletters, and your online patient portal:

How did you hear about our office:
☐ Church Bulletin ☐ Internet/Search Engine ☐ Magazine _____
☐ Insurance Company ☐ News Segment ☐ Patient Referral _____ ☐ Physician Referral ☐ Real Self ☐ Sign
☐ Social Media ☐ Website ☐ Word of Mouth ☐ Other_____

May we discuss scheduling, Billing and/or your medical condition with any member(s) of your household:

If "Yes", whom(LIST ALL) **Relationship:**

Emergency Contact:
(If different from above) **Phone:** **Relationship:**

Parent/Responsible Party:
(If the patient is a minor) **DOB:** **Relationship:**

Responsible Party Address:
(If different from patient) **SSN:**

Primary Insurance Name: **Policy #:** **Group #:**
Subscriber/Policy Holder: **DOB:** **SSN:**

Secondary Insurance Name: **Policy #:** **Group #:**
Subscriber/Policy Holder: **DOB:** **SSN:**

BY SIGNING THIS FORM I CONSENT TO BE TREATED AT CENTER FOR DERMATOLOGY & PLASTIC SURGERY

PAYMENT POLICY

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay for any non-covered services and co-payments. In the event that your account becomes delinquent, a $25 late fee may be added to your account. Returned checks will incur a $25 additional fee. If your account becomes delinquent and we are unable to collect, your account will be sent to collections, and you will be responsible for your balance plus the collection fee of up to 50% of your balance.

CANCELLATION AND NO-SHOW POLICY

We ask that you give at least 24 hours notice in the event that you must cancel your appointment. All appointments cancelled within 24 hours will be considered "No Show." "No Show" will result in a $50 fee ($75 fee for cosmetic/surgeries), per instance, added to your account. We don't bill for preventive care. It is the responsibility of the patient(s) to obtain referrals.

AUTHORIZATION TO RELEASE INFORMATION AND RECEIVE PAYMENT

I authorize the release of medical information to my primary or referring physician, to consultants, if needed, and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to the physician.

By signing below, I acknowledge that I have read, understand, and agree to the Notice of Privacy Practices, Patient Rights, and Office Policies:

Patient or Parent/Guardian Signature: Date: