RidgeView DERMATOLOGY

Date ____/____/_____

Chart # _____

PATIENT INFORMATION:

Name: _____ DOB: ____/____/_____ SSN: ____-____-_____

Address: _____ Phone (H) (____) ____-_____ Gender: M F

_____ Phone (C) (____) ____-_____ Race: _____

*OK to leave message with personal health information on voicemail of above phones: Y / N

Employer: _____ Occupation: _____

Address: _____ Phone (W) (____) ____-_____

_____ Email Address: _____

Marital Status: S M D W N/A

RESPONSIBLE PARTY (Complete only if patient is a minor or otherwise not financially responsible):

Name: _____ DOB: ____/____/_____ SSN: ____-____-_____

Address: _____ Phone (H) (____) ____-_____

_____ Phone (C) (____) ____-_____

Employer: _____ Occupation: _____

Address: _____ Phone (W) (____) ____-_____

_____ Email Address: _____

Primary Insurance

Company Name: _____

ID#: _____

Group #: _____

Insured Name: _____

Insured DOB: ____/____/_____

Relationship to Patient: _____

Insurance Address: _____

_____

Insurance Phone#: (____) ____-_____

Secondary Insurance

Company Name: _____

ID#: _____

Group #: _____

Insured Name: _____

Insured DOB: ____/____/_____

Relationship to Patient: _____

Insurance Address: _____

_____

Insurance Phone#: (____) ____-_____

EMERGENCY CONTACT:

Name: _____ Phone (H) (____) ____-_____

Relationship: _____ Phone (C) (____) ____-_____

Phone (W) (____) ____-_____

-OVER-

PHARMACYINFORMATION:

Pharmacy: _____ Address: _____

Phone: (____) ____-_____ _____

Who is your PRIMARY CARE PROVIDER?: _____

Who REFERRED you to our practice?: _____

For What Reason (OPTIONAL)?: _____

<u>Please read the following statements carefully and sign below:</u>

All of the information that I have provided on the patient information forms is true and complete. I understand that the signature below will also be used as a "signature on file" for insurance purposes, including any medical information necessary to process relevant claims.

I hereby authorize all physicians and staff of *RidgeView Dermatology* to administer any treatment and to perform any procedure as may be deemed necessary or advisable for my diagnosis and/or treatment.

I hereby assign my insurance benefits to be paid directly to *RidgeView Dermatology*. I authorize the release of medical information necessary to process claims to my insurance company/companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims.

I certify that the insurance information I have provided above is accurate, complete, and that the coverage I have listed above is currently active and not expired. I have read the *RidgeView Dermatology Financial Policy Statement* and agree that I am ultimately responsible for any and all non-covered services.

Printed Name: _____

Signature: _____ Date: ____/____/_____

RidgeView DERMATOLOGY

Name _____

DOB_____/____/_____

FINANCIAL DISCLOSURE POLICY

Thank you for choosing *RidgeView Dermatology*. We are dedicated to providing you with the best possible service. In order to reduce any potential misunderstanding, we have adopted the following financial policy. We regard your complete understanding of this policy as an essential element of your care and treatment.

- This office maintains contracts with multiple insurance companies. Although our reception staff may assist you in determining if your individual plan is one with which we have a contract, ultimately it is your responsibility to confirm insurance coverage.

Please **Initial** the following to acknowledge understanding of each statement.

X_____It is your responsibility to be aware of your specific insurance policy deductibles, co-payments, and co-insurance. It is your obligation to remit all appropriate payments. The amount for which you are responsible (any deductibles, co-payments, co-insurance/percentage, or non-covered services) will be required, without exception, at the time of service.

X_____Your insurance benefits may be verified to estimate the amount that you will be responsible for remitting at the time of service. This amount represents our best faith effort to determine your financial responsibility. It is NOT a guarantee of payment by your insurance company. It is NOT a guarantee of the total amount that you will ultimately be responsible for remitting.

X_____You will be responsible for payment in full of any denied charges in the event that your insurance company determines a service is "not covered," "not medically necessary," a "cosmetic procedure," or denies payment for any reason.

- If you have out-of-network benefits, all charges will be due, without exception, at the time of service.
- If this practice is not contracted with your specific insurance plan, all charges will be due, without exception, at the time of service.
- Your insurance policy is a contract solely between you and your insurance company. If you fail to notify us of an insurance change, you will be fully responsible for any amount not paid by your insurance company.
- For service rendered to minor patients, the accompanying parent or guardian will be responsible for payment.
- If laboratory services (pathology, wound culture, etc.) are required as part of your care, you will receive a separate bill from the laboratory company performing such testing.

X_____All account balances (including no-show and cancellation fees) are due within 30 days of the date of your billing statement. After 30 days, additional charges will be applied.

-OVER-

X_____This office utilizes a Collection Agency to pursue unpaid account balances (not paid within 90 days of the initial patient statement) and to report unpaid account holders to all applicable credit bureaus. Should your account be turned over to our Collection Agency, a twenty-five percent (25%) collection fee will be automatically added to your past due balance. In addition, you will be responsible for any and all associated fees including, but not limited to, attorney, court fees, and 18% annual interest on any unpaid balance from last date of service.

X_____If my account is placed in collections, I authorize my employer to release all information regarding employment and salary verification.

X_____I further understand there is a $50.00 fee for all returned checks.

X_____You agree, that in order for us to service our account or to collect any amounts you may owe, RVD and or our Collection Agency may contact you by at any telephone number associated with your account.

CANCELLATION POLICY:

We make every effort to see patients at their scheduled appointment time and thus we do not "overbook" appointments. We kindly ask that you give us at least one (1) business day notice if cancellation is necessary. Therefore, if you do not cancel your scheduled appointment with at least one (1) business day notice or you do not arrive for your scheduled appointment, you will be charged a fee of $50 for a missed office appointment. A fee of $150 will be charged for a missed surgical/procedure appointment (Mohs surgery, excisional surgery, surgical reconstruction, cosmetic procedure, etc.). This fee will not be covered by your insurance company.

X_____

If at any time you are concerned about the cost of a procedure proposed by your provider, a staff member from our business office will be happy to discuss the cost with you. Should you have any questions regarding this financial policy, you may discuss them with our office manager.

PAYMENT POLICY

It is my responsibility to confirm that my medical provider is covered under my insurance plan. I hereby authorize the assignment of all benefits (payments) directly to *RidgeView Dermatology* for all my insurance claims related to services received. I understand that I am financially responsible for any and all services provided to me which are not covered by my insurance carrier, regardless of the nature of the non-coverage.

*Please be aware that if a balance remains unpaid, you and/or your immediate family members will be discharged from this practice.

I have read, understood, and agree to abide by the financial and cancellation policies of *RidgeView Dermatology* as outlined above.

Printed Name: _____

Signature: _____ Date:_____/____/_____

RidgeView DERMATOLOGY

Name _____

DOB ____/____/_____

Patient Notice of Privacy Practices

This section summarizes how medical information about you may be disclosed. Please review this information carefully. RidgeView Dermatology will use your medical information for the following:

- **Treatment:** This includes providing your medical records to consulting medical providers and insurance companies.
- **Payment:** We will file necessary claims to insurance companies in your name to obtain payment. Insurance companies may request a portion or all of your medical record.
- **Healthcare Operations:** This includes all others involved in your healthcare.

The entire Notice of Privacy Practices of RidgeView Dermatology will be provided to you at your initial appointment and is also available to view in our waiting area and on our website at www.ridgeviewdermatology.com.

By signing below, I acknowledge receipt of the entire Notice of Privacy Practices of RidgeView Dermatology.

Printed Name: _____ **Signature: X**_____ **Date** ___/___/_____
Patient or Legal Guardian Patient or Legal Guardian

If not patient, your relationship to patient: _____ **Witness:** _____

Release of Medical Records

I authorize the release of any medical information necessary to my primary care and/or referring physician and to any consultants as necessary. I authorize the release of any necessary medical information in order to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to *RidgeView Dermatology*. I permit a copy of this authorization to be used in place of the original.

Printed Name: _____ **Signature: X**_____ **Date** ___/___/_____
Patient or Legal Guardian Patient or Legal Guardian

Communication Release

- May we leave personal medical information on your answering machine or voicemail? ☐ YES ☐ NO
  If yes, please check all that we may leave information on: ☐ HOME ☐ CELL ☐ WORK
- May we e-mail personal medical information to you? ☐ YES ☐ NO
- May we use email and/or text messaging for appointment reminders and other communication? ☐ YES ☐ NO
  E-mail _____
  Cell/text number _____

I authorize *RidgeView Dermatology* to disclose medical information pertaining to my diagnosis and/or treatment, laboratory results, medical history, or any such related information to those listed below (limit 3):

Name	Phone #	Relationship
Name	Phone #	Relationship
Name	Phone#	Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of information to other healthcare providers associated with my care to facilitate further treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

Printed Name: _____ **Signature: X**_____ **Date** ___/___/_____
Patient or Legal Guardian Patient or Legal Guardian

RidgeView DERMATOLOGY

Name _____

DOB ____/____/_____

PHARMACY INFORMATION:

Pharmacy: _____ Address: _____

Phone: (____) ____-_____ _____

MEDICATIONS (List ALL including OTC and Vitamins/Supplements)

_____

_____

_____

_____

ALLERGIES (List Medication AND the Reaction you experienced): _____

_____

Allergy to LIDOCAINE or EPINEPHRINE?	☐ Yes	☐ No
Allergy to LATEX?	☐ Yes	☐ No
Allergy to ADHESIVES?	☐ Yes	☐ No
Allergy to TOPICAL ANTIBIOTIC OINTMENTS?	☐ Yes	☐ No

PREGNANT or PLANNING PREGNANCY?	☐ Yes	☐ No	☐ N/A
ANTIBIOTICS before ROUTINE DENTAL CLEANINGS?	☐ Yes	☐ No	
Problems with BLEEDING after dental work?	☐ Yes	☐ No	
Problems with POOR HEALING?	☐ Yes	☐ No	
Problems with POOR SCARRING/ KELOIDS?	☐ Yes	☐ No	

SOCIAL HISTORY

SMOKER?	☐ Yes	☐ No	How many pack/day? _____
FORMER SMOKER?	☐ Yes	☐ No	
ALCOHOL?	☐ Yes	☐ No	How many drinks/day? _____
REGULARLY USE SUNSCREEN?	☐ Yes	☐ No	If yes, what SPF? _____
CURRENT OR PAST USE OF TANNING BED?	☐ Yes	☐ No	

OCCUPATION: _____

Initial _____ --OVER--

PLEASE CIRCLE ALL THAT APPLY

FAMILY HISTORY: ☐ None

Family history of Melanoma, skin cancer, or other skin problems: (Describe) _____

PAST MEDICAL HISTORY (If yes, please describe): ☐ None

Abnormal Moles _____

Asthma/Breathing Problems _____

Arthritis/Joint Problems _____

Behavioral Problems _____

Bleeding Problems _____

Blistering Sunburns _____

Cancer _____

Diabetes _____

Ear/Nose/Throat Disorder _____

Eye Disorders _____

High Cholesterol /Blood Pressure / Heart Defect _____

Seasonal Allergies _____

Seizures _____

Thyroid Disorder _____

Other Medical Problems: _____

PAST SURGICAL HISTORY (Please list any surgeries with approximate dates): ☐ None

_____

Has the patient ever had a blood transfusion? Y / N Describe: _____

REVIEW OF SYSTEMS- Please circle any of the following that the patient has experienced in the past 1 month: ☐ ALL None

Constitutional: Weight loss / Weight Gain / Fever (>101.5) / Feeling Poorly / **NONE**

Eyes / ENT: Itchy Eyes / Eye Drainage / Dry Eyes / Ear Infection / Runny Nose / Sore Throat / Seasonal Allergy Symptoms / **NONE**

Cardiovascular / Respiratory: Chest Pain / Heart Rate Problem / Shortness of Breath / Wheeze / Cough / **NONE**

Gastrointestinal / Genitourinary: Nausea / Vomiting / Constipation / Trouble Urinating / Abnormal Vaginal Bleeding / **NONE**

Musculoskeletal / Skin: Joint Pain / Stiffness / Swelling / Skin Lesions / Skin Rash / Excessive Sweating / Itching / **NONE**

Neurological / Psychological: Seizure / Fainting / Weakness / Behavioral Problems / Depression / Anxiety / **NONE**

Heme / Lymph: Easy Bruising / Easy Bleeding / Nosebleeds/ Swollen Glands / **NONE**

Other (Please Describe):_____

Is there any other information that you feel we should know?_____

_____

Who is your PRIMARY CARE PROVIDER?: _____

Who REFERRED you to our practice?: _____

For What Reason (OPTIONAL)?: _____

Sign _____ Date ___/___/_____