Dermatology Specialists

REGISTRATION SHEET – PLEASE COMPLETE

Last name _____
First name_____MI___
(As printed on Insurance card if applicable)
Date of birth_____

Primary Care Physician _____
Telephone # of PCP_____
Referring Provider_____

Sex: M or F
Address line 1_____
Address line 2_____
City_____
State _____ Zip_____
Home phone_____
Cell phone_____
Work phone_____
Preferred pharmacy name & location:
_____
Email address_____
(for DS purposes only will not be shared)

Marital status: S/ M/ W/ Partner
Social Security #_____
Employer name_____
Race/Ethnicity _____
Preferred Language _____
How did you hear about us?
Other Patient _____ Referral _____ Ad_____
Emergency contact_____
Phone #: _____
Relationship to Patient:_____

Primary Insured Responsible Party (Fill out this portion if different from Self)

Name: Self / Other Named _____MI: _____ DOB_____
Address:_____City_____State_____Zip_____
Telephone #:_____Relationship to Pt_____
Subscriber # _____ Group #:_____

INSURED RESPONSIBILITY: It is understood that services rendered by DS are to the patient, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. It is not the responsibility of DS to collect from the insurance company. We do this as a service to our patients.

PATIENTS: I understand that if my insurance company refuses to pay for services rendered because they feel the services are not medically necessary or is pre-existing, that I am responsible to promptly pay the balance in full.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All returned checks (NSF, Account Closed, Refer to Maker, or Uncollected Funds) are subject to a $40 service charge and cost of collection fee. In consideration of any services rendered by DS, or associated health care provider, I agree to be responsible for the payment of all services notwithstanding any insurance coverage I may have. If it is necessary for DS to employ anyone, including collection agencies and attorneys, to collect such payments, then I shall be responsible to pay reasonable fees and costs, as well as a $25 surcharge, in addition to said payment.

I certify that the information given by me in applying for payment is correct. I authorize any holder of medical or other information about me to release to any referring physician, consultants as needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to DS.

Do we have your permission to:
1) Is it ok to leave a detailed message? Yes ___ No ___ Preferred # Home _____ Cell_____
2) Discuss your medical condition with any member of your family? If yes Whom? _____Relationship:_____
Whom? _____Relationship:_____

in signing this document, I am attesting that I have read the above and that I have had all of my questions answered to my satisfaction.

_____ _____

PATIENT SIGNATURE/LEGAL GUARDIAN DATE

Dermatology Specialists- **Medical History**

Patient Name: _____ Preferred Name: _____

Date of Birth: ___/___/____ Today's Date:__/__/___

Sex assigned at birth: _____ Preferred Pronouns: _____ What is your height? ___ft___in Weight? _____lbs

Current Medications (prescriptions only):

_____

Do you currently take any blood thinners? (Including fish oil/aspirin) _____

Medication allergies: _____

Other allergies (bandages, adhesives, foods, environmental, local anesthesia): _____

_____

Do you have, have you ever had, or been treated for the following diseases or conditions of: (Please check for YES)

Skin

☐ Blistering sunburns

☐ Basal Cell Carcinoma

☐ Squamous Cell Carcinoma

☐ Melanoma

☐ Atypical Nevus

☐ Family History of Melanoma

Infections

☐ Cold sores/ fever blisters/ herpes

☐ Hepatitis (circle one) A B C

☐ HIV / AIDS

Other Diseases or Conditions

☐ High blood pressure

☐ Implanted Devices (Pacemaker, defibrillator, cochlear implant) (circle one)

☐ High Cholesterol

☐ Diabetes (list type)

☐ Thyroid Condition (please specify)

☐ Kidney Disease

☐ Liver Disease

☐ Anxiety / Depression (circle)

☐ Immunosuppression / Organ Transplant

☐ Bleeding or Clotting Disorder

List any other diseases or conditions _____

List any surgeries you have had: _____

Do you smoke? Yes No Do you use IV drugs? Yes No Do you drink alcohol? Yes No If yes, how much? _____

Are you Pregnant? Yes No Are you Breastfeeding? Yes No Trying to conceive? Yes No

What is / was your occupation? _____ Hobbies? _____

Patient/Representative Signature: **X**_____ Date ___/___/___

Reviewed By: **X**_____ Date ___/___/___

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Insurance Authorization And Assignment, I hereby authorize Dermatology Specialists to furnish information to insurance carriers concerning my diagnosis and treatments and I hereby assign to the physicians all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance and all collections costs should this account be assigned for collection. I accept and understand the responsibility of notifying DS of any requirement by my insurance company of pre-authorization prior to any surgical procedure. I understand that if I fail to get a referral, if necessary, I will be responsible for the charges.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

FOR OFFICE USE ONLY

This consent was signed in front of _____

DERMATOLOGY SPECIALISTS
SURGICAL · MEDICAL · COSMETIC

T 303-442-6647 F 303-442-2696 WWW.DSDERM.COM

Conscientious care delivered, together

Cancellation and No-Show Policy for Providers

We schedule our appointments so that each patient receives the right amount of time and attention from our providers. As a courtesy, and to help patients remember their scheduled appointments, Dermatology Specialists sends out multiple reminders (via call, text and email) in advance of your appointment time. If your schedule changes and you cannot keep your appointment, please let us know via a phone call during regular business hours of 8am-4:30pm Monday-Friday at 303-442-6647 or by sending a text message to our main number at 303-442-6647 by 10am the business day PRIOR to the scheduled time to avoid being charged a no-show fee. Monday appointments need to be cancelled by 10am the Friday before the appointment is scheduled. Patients who do not show up for their appointment or do not provide the proper notification by cancelling their appointment by 10am on the prior business day will be charged a $75 no-show fee. This fee is NOT covered by insurance and must be paid in full by the patient prior to scheduling their next appointment. Please note that a continued history of no-shows or cancellations with less than 1 business days' notice may result in dismissal from Dermatology Specialists.

Cancellation and No-Show Policy for Estheticians

Effective June 9, 2023. Dermatology Specialists will be requiring patients to keep a card on file when scheduling all esthetician appointments. If the patient does not cancel/reschedule their appointment by 10am the prior business day or if they no-show for their appointment, a $75 no-show/cancellation fee will be charged to the patient's card on file. Monday appointments need to be cancelled by 10am the Friday before the appointment is scheduled. These "no-show charges" are not reimbursable by your insurance company, and you will be charged directly. Please note that a continued history of no-shows or cancellations with less than 1 business days' notice may result in dismissal from Dermatology Specialists.

I have read and understand the Cancellation and No-Show Policy for Dermatology Specialists.

Patient/Guardian Signature: _____ Date: _____

Printed Patient Name/Guardian: _____ DOB: _____

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Financial Policy

Thank you for choosing Dermatology Specialists! Our practice firmly believes that a good physician/patient relationship is based upon good understanding and clear communication. We are committed to the success of your medical care and well-being. Please understand that payment for your financial responsibility is necessary for us to be able to continue to serve you and our community. To help avoid misunderstandings, our financial policy is in writing below.

Patients/guarantors are responsible for understanding their insurance benefits. We may be able to help explain your insurance, but it is always best for you to speak with them directly as we do not have your plan agreement available to us. For example, many procedures performed in our office may apply towards your deductible or co-insurance. These are expenses that are beyond your specialist copay. **We do not bill preventative services codes. Dermatology is a "problem oriented" specialty and we only address and treat one body system "the skin", therefore we do not meet the criteria required to bill preventative codes.** You will need to know what your insurance responsibility may be.

All biopsies and mole removals performed in our office may be submitted for pathology for analysis. Some of the tissue may be processed in our in-office lab or sent to an outside pathology lab. Please note that depending on your benefits, you might receive a separate bill for pathology. **Tests and treatments performed in our office are necessary to ensure proper diagnosis and care for our patients.** Below are some examples of procedures (classified as surgery by most insurance companies) that could be applied towards deductibles and co-insurance:

- Biopsies and lesion removals. This includes all excisions for skin cancer and atypical moles or benign lesions.
- Liquid nitrogen for the destruction of lesions (warts and pre-cancerous lesions)
- Injections
- Photodynamic Therapy (PDT)

All copays and outstanding balances are due at the time of service unless other arrangements have been made in advance.

Our practice accepts cash, checks, money orders, Visa, MasterCard, Discover and American Express as forms of payment. Returned checks will be assessed a fee of $40. Please note that delinquent accounts will be subject to the services and fees of a collection agency.

I have read and understand the Financial Policy for Dermatology Specialists. I agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charges by the collection agency for the cost of collections.

Patient/Guardian Signature: _____ Date: _____

Printed Patient Name/Guardian: _____ DOB: _____