DERMATOLOGY CLINIC, P.C.

Last Name: ____________________________________ First Name: _____________________ MI: ____________

Address: ____

City: __________________________________ State: _________ ZIP Code: ______________

SS# ________-_______-__________ Date of birth: _____/_____/_______ Gender: M / F

Home Phone: _________________ Cell: ___________________ May we leave messages for you at this number? Yes No

Mailing Address: (if different) ____

Primary Care Physician: ____ Phone: ________________________

Referred by: ____________________________ If referred to us by a physician, please include their telephone number: ________________________________

Patient's Employer: ____ Work Phone: ___________________

Should we call you at work? Yes No May we leave messages for you at work? Yes No

If patient is a minor: Parent's Name: ______________________________ Phone: ________________

Name of Insurance Company: ____

Policy holder's name: ____ Date of birth : ______/______/________

Policy holder's SS#: ________-_______-__________ Policy number: __________________________________

Group name / Number: ____

Relationship to patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other

In case of emergency contact: ____ Phone: _______________________

Relationship: May we speak to this person regarding your care? Yes No

FINANCIAL & INFORMATION RELEASE

Payment is expected at the time of service, insurance co-payments are mandated by your insurance company and **MUST** be made today. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I understand and agree that if the insurance company denies benefits for any reason, **I am responsible for the full amount of services provided**. I understand that the definition of "non-covered" or cosmetic procedures is made solely by my insurance company.

I request that payment of authorized insurance / Medicare benefits be made payable to Dermatology Clinic, P.C. (FEIN 26-4219515) on my behalf for services furnished to me. In the event that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection including attorney fees, collection fees and court costs and understand that I am no longer a patient at this office. I understand and agree to pay a returned check charge of $40.00 per returned check for any reason.

I authorize any holder of medical information about me to release any and all information to the health care financing administration, its agents, or my insurance carrier as needed to determine these benefits or the benefits for myself or my dependants. If I have health insurance coverage under an HMO or it is requested by any of my physicians, I authorize Dermatology Clinic, P.C. to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit

Signature of **PATIENT (parent) or INSURED**: ______________________________________ DATE: ______________

DERMATOLOGY CLINIC, PC

Patient History Form

Name ____ Date of Birth _______________Date _____________

1st Visit only: *What are you being seen for?* ____

Current medications including any creams or lotions, birth control, over-the-counter medicines, vitamins, and supplements:____

____

Any allergies to medicines? (include name) ____

Hay fever or other allergies? ____

<u>Your</u> past skin history

Do you have history of malignant melanoma, basal cell carcinoma, squamous cell carcinoma, or pre-cancerous actinic keratosis? (circle all the apply)	Y	N
Do you use tanning beds?	Y	N
Have you ever been severely sunburned?	Y	N
Any radiation or ultraviolet treatments?	Y	N

Family History

Has anyone in your family had a malignant melanoma or any other skin cancer?	Y	N

Who? ____

What type?(ie basal, squamous) ________________________

<u>Your</u> past medical history

Do you have any heart disease, heart problems, pacemakers?	Y	N
Explain: ____		
Do you have arthritis or artificial joints?	Y	N
Do you require antibiotics before dental or surgical procedures?	Y	N
Are you diabetic?	Y	N
Do you use insulin?	Y	N
Are you a smoker?	Y	N
Are you HIV positive?	Y	N
Any history of hepatitis?	Y	N
Any other major health problems not listed?	Y	N

If Yes:

____

If you are a female, is there a possibility that you are pregnant, or are you presently trying to become pregnant?	Y	N

Please explain any other circumstance that the doctor may need to be aware of: (please continue on back if needed)

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Dermatology Clinic, P.C.

Notice of Privacy Practices – Patient Acknowledgement

The Staff at Dermatology Clinic, P.C. are committed to safeguarding the privacy and confidentiality of your medical record including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following:

Patient Name (please print) ___________________________________

Date of Birth: _____________________

Please indicate the order in which we should attempt to reach you (1=first number to try, etc):

☐ Cell Phone: _____________________

May we leave a voice message for you here? Y N

☐ Home Phone: _____________________

May we leave a voice message for you here? Y N

☐ Work Phone: ________________________

May we call you at work? Y N
May we leave a voice message for you at work? Y N

May we speak to someone else regarding your medical care? Y N

Name of person: Relationship:

____________________________________ _________________

____________________________________ _________________

I have been made aware of the privacy policies of Dermatology Clinic, P.C. and have received (or reviewed or been given the option to receive) a copy of the HIPAA Notice of Privacy Practices.

Signed: ____________________________________ Date: ______________

Dermatology Clinic, P.C.
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www.coloradospringsdermatologist.com

Larry W. Cole, M.D.
Elizabeth W. Piantanida, M.D.
Patrick J. Galaska, PA-C

Certified by the American Board of Dermatology
Fellows of the American Academy of Dermatology

We are pleased that you have chosen our group of specialists for your skin care. We are sending this information to you ahead of your appointment to make your visit to our office as convenient as possible. Our office hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

Patient Registration Form: Please complete these forms before you arrive and be sure to bring them with you to your first visit.

Please note that patients under the age of 18 must be accompanied by a parent or guardian or have a written and signed authorization from the parent or guardian for treatment or follow up appointments. In some cases, verbal consent is acceptable. Please discuss the possibility and necessity with a nurse during the first visit.

Referrals: If you have HMO insurance, you will need a referral from your (PCP) primary care physician to see a dermatologist. Referrals are your responsibility and are generated by your PCP's office then submitted to the insurance company. Once approved, the insurance company will send you a copy - ***please bring a copy of your referral with you***. Your appointment will need to be rescheduled if you do not have a valid referral.

Insurance Cards: Please bring your card with you. We must be able to make a copy of it.

Co-payments: Co-pays are amounts that you have agreed with your insurance company to pay for each medical office visit. If you do not have the required co-payment with you, our agreement with your insurance company may force us to reschedule your appointment.

Insurance Claims: We will, for your convenience, submit your health claims using the insurance information that you have provided. If you change insurance coverage, please be sure to let us know upon arrival. Be aware that many insurance plans include deductible amounts that are also your responsibility. Please be prepared to pay these amounts at your next visit. Our billing department at 484-8842 ext. 105 can answer questions regarding these amounts.

Late or missed appointments: We take great care in organizing the schedules of the doctors to accommodate as many people as possible. Please call ahead and let us know if you will be late or need to reschedule an appointment at 484-8842 ext. 100.

Surgery: Be sure to ask for any appropriate "after care" instructions to take with you for later reference. Also be aware that many insurance companies have separate surgery deductible amounts that you must meet. Pathology results will be communicated to you by telephone upon receipt from the laboratory, upon doctor's orders.

Prescription Refills: If you need a refill of a prescribed medication, please call your pharmacy and they will contact us. We will call your pharmacy as soon as the doctor approves the refill, then call to notify you. If you are told by your pharmacy to contact us for some reason, you may be asked to leave a voice mail depending on our office activity. Be sure to leave a return telephone number, your name, birth date, name of medication and preferred pharmacy name and their telephone number. The triage nurse's direct number is 484-8842 ext. 112 if you do have additional questions. Please note that we can not refill prescriptions on the weekend or holidays.

Visit us on the web at: www.coloradospringsdermatologist.com