



Patient Name Last _____ First _____ MI _____ Nickname _____

Date of Birth _____ Sex _____ Preferred Language _____

Relationship Status _____

Spouse's Name _____ Spouse's Phone Number _____

In case of an emergency, who should we notify? _____

Relationship _____ Phone Number _____

Do you authorize Elevated Dermatology to leave a detailed voicemail? Yes | No

Phone Number: (Please circle your preferred number)

Home _____ Cell _____ Work _____

Home Address _____ City _____ State _____ Zip _____

Email Address _____ Occupation _____

Do you give Elevated Dermatology permission to discuss your medical information including but not limited to: biopsy results, lab results, or other test results with family members? Yes | No

Disclose to _____ Relationship _____ Phone _____

Primary Care Physician _____ Fax Number _____

Address _____ Phone Number _____

Preferred Pharmacy _____ **City & Crossroads** _____

How were you referred to us?

Physician | Friend | Relative | One of our Patients | Internet | Brochure | Website | Facebook | Ad

Referred by _____

Referring Provider _____ Fax Number _____

Address _____ Phone Number _____

Insurance Provider _____ Policy Number _____

Provider ID _____

Responsible Party (person responsible for balance not covered by insurance, if different from patient)

Name _____ Relationship _____

Date of Birth _____ Home/Cell Phone _____

PATIENT HEALTH HISTORY FORM

Today's Date: ____/____/____ Patient's Name: _____ Date of Birth: ____/____/____

Reason for Today's Visit: _____ Height: _____ Weight: _____

Past medical history (Please circle all that apply)

Anxiety	Arthritis	COPD
Depression	Diabetes	End Stage Renal Disease
GERD	Hearing Loss	Hypercholesterolemia
Hypertension	Hyper/hypo thyroidism	Infectious Endocarditis
Other: _____	Other: _____	Other: _____

Causes of immunosuppression (Please circle all that apply)

Leukemia	Lymphoma	Bone Marrow Transplant
Breast Cancer	Colon Cancer	Lung Cancer
Other Cancer	HIV/AIDS	Medication/Other: _____

Past surgical history (Please circle all that apply)

Joint Replacement Date: _____	History of Infected Prosthetic Joint	Implanted Devices
Other: _____	Other: _____	Other: _____

Surgeries with immunosuppression (Please circle all that apply)

Heart Transplant	Kidney Transplant	Liver Transplant
Other Organ Transplant Organ: _____	Other: _____	Other: _____

Have you had any of the following skin conditions? (Please circle all that apply)

Basal Cell Carcinoma Location/Year: _____ Doctor: _____	Squamous Cell Carcinoma Location/Year: _____ Doctor: _____	Melanoma Location/Year: _____ Doctor: _____
Location/Year: _____ Doctor: _____	Location/Year: _____ Doctor: _____	Location/Year: _____ Doctor: _____
Location/Year: _____ Doctor: _____	Location/Year: _____ Doctor: _____	Location/Year: _____ Doctor: _____
Acne	Actinic Keratoses	Blistering Sunburns
Dry Skin	Eczema	Flaking or Itchy Scalp
Hay Fever/Allergies	Hives	Poison Ivy
Atypical/Abnormal Moles	Psoriasis	Rosacea
Excessive Sweating	Other: _____	Other: _____

Sun exposure

Do you wear sunscreen? Y | N If yes, what SPF? _____

Do you tan in a tanning salon? Y | N

Have you ever tanned in a tanning salon? Y | N



Family History

Melanoma Relative(s): _____	Basal Cell Carcinoma Relative(s): _____	Squamous Cell Carcinoma Relative(s): _____
Atopic Dermatitis	Eczema	Psoriasis

Females only

Are you pregnant? Y | N Currently trying to conceive? Y | N Are you breastfeeding? Y | N

If yes, how far along are you? _____

Tobacco use

Never | Former | Current If current smoker, total use per day? _____ Total years using? _____

Alcohol history

None | <1 drink/day | 1-2 drinks/day | >2 drinks/day

Have you received your flu vaccine this season? Yes | No

Have you received the pneumonia vaccine? (if <2 years old, >65 years old, or immunosuppressed) Yes | No

Allergies

Are you allergic to any medications:

Allergy to lidocaine? Y | N Allergy to latex? Y | N Allergy to adhesive? Y | N

Other known allergies:

Medications - Name and Dosage

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____
 7. _____ 8. _____ 9. _____

Cosmetic Concerns

(Please only fill out if you are interested in learning about cosmetic treatments – circle all that apply)

Fine Lines	Deep Wrinkles	Brown Spots
Areas of Redness	Acne scarring	Skin texture
Loss of volume	Loss of elasticity	Unwanted hair
Unwanted fat	Jowls	Other (please describe)

Patient Financial Responsibility

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies. **Your insurance is a contract between your insurance and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer before your visit or procedure. The patient responsible portion is set by your insurance company. It is ultimately your responsibility to pay you or your dependent's medical bills.**

Medicare & Contracted Insurance Plans

If you are enrolled in traditional Medicare or are a member of a health plan with which we participate, we will submit your claim to your insurance company. **It is your responsibility to verify that our office is in network with your insurance plan and/or to obtain a referral if required by your insurance prior to your appointment.** Our staff will collect any co-payment, coinsurance and/or deductible **at the time services are rendered** as required by your insurance carrier. We cannot legally waive copays for any reason. You will be billed for any remaining balance that your insurance provider does not pay. This amount is determined by the insurance and will vary depending on whether you have met your deductible and/or your coverage level. You will be billed in full for any services that your health plan deems as "not a benefit" or a "non-covered service".

Preventative Care

Elevated Dermatology and Skin Cancer Surgery Center **does not** provide preventative skin exams. The full body skin exams we provide are diagnostic care. This does not fall under preventative care included in the Affordable Care Act.

Secondary/Supplemental Insurance Plans

We will file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become the patient's responsibility 30 days after a claim is filed.

Non-Contracted Commercial Insurance Plans

If we do not participate with your insurance carrier, payment in full will be required by you **at the time services are rendered.**

Medicaid

We are not contracted with any Medicaid plan for primary insurance. Medicaid patients seeking services are responsible for payment in full **at the time of service.** We do accept and file claims to Medicaid as a supplement to Medicare.

Minors

A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance. However, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

***Initial here that you understand and agree to pay any portion that your insurance deems your responsibility _____**

Medical Records

Copies of pathology reports may be provided to you or another physician at no charge. Additional medical record requests and/or completion of forms (e.g. disability, life insurance, cancer policies, etc.) are subject to processing fees determined by state law. Medical records requests require time to be processed and will not be provided the same day requested.

Prescription Refill Policy

Call your pharmacy for medication refills unless it is a medication that is dispensed in office. Prescriptions refills are authorized only during normal business hours. We require 48 business hours for prescription refill authorizations. **Please notify your pharmacy at least 5 business days before you are out of your medication.**

Collection Fees

Statements are sent out monthly for patients with balances and payment is due within 30 days of the statement date. If you are unable to pay the balance in full, please contact our billing department at 720-484-3106. Outstanding personal balances over 90 days from the date of service will be sent to our collection agency. You will be responsible for any collection fees including court costs, attorney fees and collection agency charges.

Returned Check Fee

A \$25 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid by cash or credit card within 14 days of the date we learn of the insufficient funds.

Pathology Fees

Elevated Dermatology and Skin Cancer Surgery Center, PC (EDSCSC) has an on-site dermatopathologist who interprets our patients' biopsy and excision specimens. Fees associated with this service are separate from the procedure performed by your treating provider. In the event our dermatopathologist chooses to send your specimen for a consultation or second opinion, you or your insurance may receive a bill from this outside lab for their services. Elevated Dermatology and Skin Cancer Surgery Center providers reserve the right to send their patients' specimens to the most qualified dermatopathologist of his or her choosing. If your insurance requires the use of a specific pathology lab, **it is your responsibility to provide us with that information prior to being seen.** Failure to do so may result in additional out-of-pocket costs to you.

Name of required pathology lab (if applicable): _____

Cosmetic Services

Patients must pay for cosmetic procedures at the time of service. We do not bill insurance for cosmetic procedures.

Missed Appointments

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time we reserved for you. **Cancellations must be made a full business day (24 hours) in advance we will assess a fee of \$75 for an office visit or photodynamic light therapy. Cancellations must be made 2 business days (48 hours) in advance for any surgical appointment or we will assess a fee of \$250. Cancellations must be made 2 business days (48 hours) in advance for any cosmetic appointment or we will assess a fee of \$250 - \$750 depending on the procedure.*Initial here if you understand and agree to adhere to this Cancellation Policy:** _____

My signature below indicates that I have read, understand and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

Patient's Printed Name

Patient's Signature

Date

ACKNOWLEDGMENT OF PRIVACY PRACTICES

Thank you for choosing Elevated Dermatology and Skin Cancer Surgery Center, PC for your healthcare needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have reviewed and acknowledge our Notice. If you would like a copy, one can be provided for you.

Signature of Patient (or Legal Representative)

Patient/Representative's Printed Name

Date