Elevated Dermatology and Skin Cancer Surgery Center
10345 Parkglenn Way, Suite 100, Parker, CO 80138
Phone: 720.851.5200 Fax: 720.851.5222

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_____

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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: _____ Location/Year: _____ Doctor: _____ Location/Year: _____ Doctor: _____	Squamous Cell Carcinoma Location/Year:_____ Doctor: _____ Location/Year: _____ Doctor: _____ Location/Year: _____ Doctor: _____	Melanoma 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

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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)

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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 product you have purchased and is a contract between your insurance company 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. **Please remember that it is ultimately your responsibility for the payment of all medical bills.**

Medicare, Contracted Insurance Plans and Health Share/MediShare 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. Our staff will collect any co-payment, coinsurance and/or deductible **at the time services are rendered** as required by your insurance carrier. 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 "noncovered service". In the case of HealthShare or MediShare plans, we will submit your claim(s) to these plans as a courtesy. Due to the amount of time these payers take to pay their claims, the balance will become your responsibility 90 days after the claim is filed.

Surgical Deposits: If your care requires surgery, treatment, or additional testing, you may be asked to provide a deposit on your account to schedule the surgical procedure. Our deposits range from $250.00 to $500.00 depending on the procedure. If you would like additional details to our deposit policy, please ask a staff member for a copy of our current policy and fees.

Secondary/Supplemental Insurance Plans
We are happy to 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**. Our billing department will submit a claim to your insurance company as a courtesy to you.

Medicaid
We are not contracted with any Medicaid plan.

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.

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Medical Records
Copies of pathology reports are provided to you or another physician at no charge. Any 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 and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.

Collection Fees
Statements are sent out monthly for patients with personal balances. 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 720484-3114. Outstanding personal balances over 90 days from the date of service will be sent to our collection agency. In the event an account is referred to an outside collection agency, patients will be responsible for any collection fees including court costs, attorney fees and collection agency charges.
If your account balance goes to collections, we will be unable to provide care for you again, even if you pay the collections agency.

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 performs the interpretation of our patients' biopsy and excision specimens. Fees associated with this service are separate from the procedure performed by your treating provider. Your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab. EDSCSC providers reserve the right to send their patients' specimens to the most qualified dermatopathologist of his or her choosing. Therefore, 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 are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures. We require prepayment in full at time of scheduling for certain services and a deposit to hold the appointment for services where the total cost is not known until treatment is completed (i.e. Botox, Dysport, filler, etc.).

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 of the scheduled appointment or we will assess a fee of $75 for any office visit or photodynamic light therapy. Cancellations must be made 2 business days (48 hours) in advance for any cosmetic procedure or for any surgical appointment or we will assess a fee. The fee depends on the service missed and ranges from $75-$750.

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If you would like additional details to our no show/ late cancellation policy, please ask staff member for a copy of our current policy and fees.

My signature below indicates that I have read, understand and will comply with the information contained within this financial policy.

_____

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