Medical Services Financial Agreement
Denver Skin Clinic, PC  ~  2200 East 18th Ave.  Denver, CO 80206

Insurance
If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan. Please assist us in complying with your insurance requirements.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 60 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days.** It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information is current. If you give the wrong insurance information and a referral is required, you will be responsible for the charges. We will, however, assist you to ensure that all plan requirements are met.

[Initial]

On occasion, a biopsy done by one of the physicians at Denver Skin Clinic may be submitted for review to University of Colorado Dermatopathology Consultants (UCDC). Should this become necessary, your insurance company will be billed separately by University Physicians for this service.

[Initial]

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

[Initial]

Payment for Services
Payment for services, including insurance co-payment or self-pay balance amount, is due at the time services are rendered unless payment arrangements have been approved in advance by the Office Manager. We accept exact cash, checks, MasterCard, Visa and Discover. Our failure to collect these amounts may be a violation of our contract with your insurance company. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to your employer and/or insurance company representative.

[Initial]

Please complete all lines on the Reverse side  >>>>>>>>>
Returned checks will result in a $25 fee that will be posted to your account. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. Patient will be responsible for all the collection, court and attorney fees.

please initial

**General**

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

**Cancelled Appointments**

Charges may be incurred for broken, confirmed appointments and appointments cancelled without 24 hours notice. Your cooperation in canceling your scheduled appointment well in advance allows us the opportunity to offer your appointment to a person who needs medical care. **Failure to show for a scheduled, confirmed appointment may result in a $25 cancellation fee.**

please initial

If you have any questions about the above information, please do not hesitate to ask us.

Thank you,

My signature below constitutes acknowledgement and acceptance of this policy.

Patient name – Printed: __________________________________________

Patient or guardian signature: _____________________________________

Date: __________________________________________
Today’s Date: ________

PATIENT NAME: (This section refers to PATIENT ONLY)

□ Mr.  □ Mrs.  □ Miss  □ Ms.  □ Dr.

Patient name: ____________________________________________

First name                      Middle name               Last name

Your birthdate: ____-____-______  Age: ______  Sex: □ Male  □ Female  Social Security #: _____-____-_____

Address: _________________________________  APT #: _______  City: __________________________ State: _____

Zip: ______________  

Email address: __________________________________________  

Permission to send newsletter/information: □ Y  □ N

Telephone: Primary # ____________________  Cell # ___________________  Work # ___________  ext: ______

Employer: _______________________________  Occupation: ________________________________

SPOUSE name: ____________________________  Employer: ________________________________

Telephone: work# ______________________  ext: __________

Referring physician name: ________________________________  Physician telephone #: ___________________

Primary Care physician PCP: ______________________________  Physician telephone #: ___________________

Relationship to responsible party: □ Self  □ Spouse  □ Son  □ Daughter  □ Other

RESPONSIBLE PARTY: (Person who should receive the bill)

Responsible party name: _____________________________________  Telephone: primary # __________________

Responsible party birthdate: ____-____-______  Age: _______  Social Security #: _____-____-_____

Address: _________________________________  APT #: _______  City: __________________________ State: _____

Zip: ______________  

Employer name: ______________________________  Telephone: work # ___________________ ext ______

INSURANCE: (Please complete thoroughly. We will also need a copy of your insurance cards)

Primary insurance: __________________________________________  Telephone #: _______________________

Address: _________________________________  City: __________________________ State: _____

Zip: ______________  

Policy holder name: _______________________________  ID/policy #: ___________________  Suffix: __________

Group #: __________

Employer: _______________________________  CO-PAY: $_________  Annual Deductible: $_________

Secondary insurance: ______________________________________  Telephone #: _______________________

Address: _________________________________  City: __________________________ State: _____

Zip: ______________  

Policy holder name: _______________________________  ID/policy #: ___________________  Suffix: __________

Group #: __________

Employer: _______________________________  CO-PAY: $_________

Work Comp: □ Claim #: ___________________________  Date of Accident: __________________

Other Injury (specify): □ Claim #: ___________________________  Date of Accident: __________________
NOTIFY IN EMERGENCY:

Name: ___________________________________  Relationship: ________________ Telephone #: _______________

CONSENT FOR TEST RESULTS (check all that apply)

I give Denver Skin Clinic, PC permission to leave all X-ray, lab results, test results, and other medical information and advice:

☐ Voice mail at work  ☐ Answering machine at home  ☐ Other ______________________________  ☐ Do not leave message

I hereby acknowledge that I have received a copy of Denver Skin Clinic, PC Notice of Privacy Practices. I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay, any other balance not paid by my insurance or all collection fees if my account should go to collections.

Printed name: __________________________________________

Signature: ____________________________________________  Date: ____________________

Relationship to patient: ☐ Self  ☐ Parent  ☐ Guardian
Health History
Denver Skin Clinic

Patient: __________________________________ Date of Birth: _______________ Today’s Date: _______________

**REASON** for visit: (mole, wart, acne, rash, past skin cancer, etc.): __________________________________________

Location of problem and how long you have had it: __________________________________________________________

If Acne or Rash, what have you used in the past? __________________________________________________________

What are you using now? ______________________________________________________________________________

List any **ALLERGIES** to medications and reactions: ______________________________________________________

Are you allergic to local anesthesia? : Lidocaine ___yes ___no Epinephrine ___yes ___no

Other allergies – please circle: Food Environment Bandages Creams/lotions Neosporin Latex

Have you ever had (circle all that apply): Basal Cell Cancer Squamous Cell Cancer Melanoma

Abnormal Moles Skin Cancer- but not sure what type

If yes, where & when: ________________________________________________________________________________

Have any of your family members had abnormal moles, skin cancers or pre-skin cancers? _____yes _____no

If yes, please circle the person’s relationship to you and circle which condition they had:

Father         Mother         Brother         Sister         Grandparent         Child         Cousin         Other

Abnormal Mole   Pre-Skin Cancer  Actinic Keratosis   Basal Cell   Squamous Cell   Melanoma “Not Sure”

Other types of cancer you have had: __________________________________________________________________

**Review of Systems**: please circle any of the following you have had **within the last month**:

**GENERAL**: fever - feeling “bad” - unusual weight gain/loss - muscle/joint pain - weakness - fatigue - night sweats

**HEENT**: headache - burning eyes - eye pain - drainage from the eye - runny nose - ear pain with drainage - bloody

- difficulty swallowing - tooth pain - sinus pain - change in hearing - blurry or double vision

**CHEST**: cough - chest pain - coughing up blood or pus - shortness of breath - neck pain - jaw or elbow pain - irregular heartbeat - wheezing

**GI**: nausea - vomiting - diarrhea - constipation - change in bowels - black or red bowel movements -

**GU**: pain with urination - frequent urination - pus or blood in the urine - kidney pain

Have you had an organ/bone marrow transplant: _____yes _____no Type: __________________________________________

Recreational drug use: _____yes _____no Type: __________________________________________________________

Have you previously taken antibiotics prior to dental cleanings/procedures: _____yes _____no

Smoke: _____yes _____no Packs per day: _____ Alcohol: _____yes _____no Drinks per week: _____

Hobbies: _____________________________________________________________________________________________

Please list ALL medications, both prescription and non-prescription, that you are currently taking. This includes all

vitamins, herbs, dietary supplements, birth control pills, Aspirin, etc ________________________________________________

*** We will gladly make a copy of your list of medications. ***

Please circle ALL that apply: • Artificial heart valve • Heart murmur • Pacemaker • Defibrillator • blood clots

• bleeding disorder • blood transfusions • high blood pressure • glaucoma • cataracts • diabetes

• thyroid problem • Hepatitis B • Hepatitis C • thickened scars (Keloids) • HIV • Arthritic Joint

Other medical problems/surgeries: ______________________________________________________________________

**WOMEN ONLY**: Breast feeding: □YES □NO Pregnant: □YES □NO Planning pregnancy: □YES □NO

Due date: ______________

I confirm that the above medical history is true to the best of my knowledge.

Signature: __________________________________________ Date: __________________________

Pharmacy you use/cross streets: __________________________________________ Phone: __________________________
NOTICE OF PRIVACY PRACTICES
Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you.

I understand that as part of my healthcare, the Denver Skin Clinic originates and maintains paper and/or Electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care. I understand that this information serves as:

A basis for planning my care and treatment and communication among other health professionals who contribute to my care and a tool for routine healthcare operations such as accessing quality and reviewing the competence of healthcare professionals.

A source of information for applying my clinical diagnoses and/or surgical information to the billing department for claim submission and also a means by which a third-party payer can verify that services billed were actually provided.

I understand that I can review and receive a copy of the posted Notice of Privacy Policy Practices that provides a more complete description of information, uses, and disclosures. I understand that I have the following rights and privileges:

The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, marketing, payment, or other healthcare operations by a written request specifying what information I want to limit or disclose. If I tell you not to disclose information to my commercial health plan concerning health care items or services for which I paid for in full out-of-pocket, you will abide by the request, unless you must disclose the information for treatment or legal reasons.

I have the right to request my health information in a specific way or at a specific location along with the right to inspect and receive a copy of my health information, with limited exceptions.

I have the right to request that you amend my health information that I believe is incorrect or incomplete. I must make the request to amend in writing, and include the reasons. You are not required to change the health information if the information is accurate and complete as is.

I have the right to receive an accounting of disclosures of the health information made by this practice other than the disclosures provided by me or pursuant to my written authorization. Also I will receive written notification or an email within 60 days of discovery in the event of a breach of unsecured protected health information.

Acknowledgement of Receipt of Notice of Privacy Practices

Denver Skin Clinic, PC ~ 2200 E. 18th Ave. ~ Denver, CO 80206
Cinda McClure CMM ~ Office Manager / Privacy Officer

I hereby acknowledge that I received a copy of this medical practice’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Print Name: ______________________________     Date: __________________ Telephone: _____________________
Signature:  _____________________________________ Relationship to patient: _______________________________

☐ I would like to receive a copy of any amended NPP by e-mail at: _______________________________________