

**PERSONAL INFORMATION - MINOR**

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Sex: Male Female

Child's Name: \_\_\_\_\_  
Last First Middle initial Nickname

Parent Address: \_\_\_\_\_  
Street City State Zip

Parent Home #: \_\_\_\_\_ Is it ok to leave a detailed message? Y N

Parent Cell #: \_\_\_\_\_ Is it ok to leave a detailed message? Y N

Child's Social Security Number: \_\_\_\_\_

**PARENT OR GUARDIAN INFORMATION**

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Is it ok to leave a detailed message? Y N

If married please complete the following information:

Spouses Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work phone: \_\_\_\_\_ Is it ok to leave a detailed message? Y N

***Would you like us to communicate with your primary care doctor regarding your office visits with us?***

***If so, please provide their name and phone number.***

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

**IF YOU ARE USING MEDICAL INSURANCE:**

We want your visit with us to be a satisfactory experience. It is important for you to understand your medical health insurance benefits completely.

For example, has your deductible for this calendar year been met? What might your out-of-pocket expenses be if your deductible has not been met? Your medical insurance carrier will be able to help you with these questions.

**PRIOR TO YOUR VISIT, PLEASE MAKE SURE YOU:**

Have a current insurance card to present to us.

Have a referral from your primary care physician if your insurance is Aetna HMO or Cigna HMO.

**Understand your copay and deductible amounts and agree that if there is a balance after we bill your insurance company you will be responsible for your contracted portion of your medical expenses.**  
(you may use a personal check, VISA/MC or exact cash the day of your visit)

If you have any questions or concerns please call our office at 303-322-7789.

The above information is accurate and I agree to contact the office if any contact information changes. I authorize payment of medical benefits to the physician for these services as well as future services.

\_\_\_\_\_  
Signature:(Parent or Legal Guardian)

\_\_\_\_\_  
Date

**NOTICE OF PRIVACY PRACTICES**  
**Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations**

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***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.
- A basis of communication among other health professionals who contribute to my care.
- A source of information for applying my clinical diagnoses and/or surgical information to your billing department for claim submission.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as accessing quality and reviewing the competence of healthcare professionals.

I understand that I can review the Notice of Information 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 review the notice prior to signing this consent.
- 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.

I understand that I may revoke this consent in writing, except to the extent that the Denver Skin Clinic has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of the Federal Regulations.

If I wish to restrict any information from disclosure, I will formally indicate the restrictions to the use of the health information in writing and submit it to the Denver Skin Clinic.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for I fully understand and accept the terms of this consent.

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**Patient's Signature/Date**

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**Print Name**

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**CONSENT TO RELEASE INFORMATION TO OTHER INDIVIDUALS (i.e., family members)**

I hereby give the person below authorization to receive and/or communicate on my behalf, details related to any medical information, including diagnoses, treatment, and lab results:

Name of authorized person: \_\_\_\_\_

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**Patient's Signature/Date**

# MEDICAL INFORMATION SHEET

Name: \_\_\_\_\_ Date: \_\_\_\_\_

ALLERGIES TO MEDICATIONS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. What is the reason for your visit? (please circle)      Skin check      Specific spots      Acne

Other: \_\_\_\_\_

Rash, if so:

Please list prescription products that you are using on your skin now: \_\_\_\_\_

\_\_\_\_\_

Please list non-prescription products that you are using on your skin now: \_\_\_\_\_

\_\_\_\_\_

Please list all products you have used for this condition on your skin in the past: \_\_\_\_\_

\_\_\_\_\_

2. Please list any medical conditions: \_\_\_\_\_

3. Please list all drugs, prescription and non-prescription, that you are taking for any condition:

\_\_\_\_\_

\_\_\_\_\_

4. Have you had :

Basal cell

Squamous cell

Melanoma

If yes, where on your body? \_\_\_\_\_

What year? \_\_\_\_\_

- |  |     |    |
|--|-----|----|
| 5. Do you have any family history of Melanoma?   | Yes | No |
| 6. Do you have any family history of basal cell/squamous cell?                                       | Yes | No |
| 7. Did you have painful/ blistering sunburns as a child?   | Yes | No |
| 8. Has a doctor recommended, that for any reason, before every surgery, you should take antibiotics? | Yes | No |

# Treatment to Minors

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

I hereby grant Denver Skin Clinic permission to treat my child listed below when he/she arrives at the office unaccompanied.

***PLEASE PRINT***

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

If needed, please try to contact me regarding health care of my child at the following phone numbers:

Parent's Name: \_\_\_\_\_

*If relationship is other than Parent:*

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Primary phone number: \_\_\_\_\_

Secondary phone number: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# MEDICAL SERVICES FINANCIAL AGREEMENT

## 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. We will, however, assist you to ensure that all plan requirements are met. X\_\_\_\_\_ (Please initial)

## Payment for Services

**Payment for service, including co-payment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.** We accept cash, checks, MasterCard, Visa, and Discover. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. 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 pay these amounts to your employer and/or insurance company representative. X\_\_\_\_\_ (Please initial)

**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. X\_\_\_\_\_ (Please initial)

## **Cancelled Appointments**

Charges may be made for broken, confirmed appointments and appointments cancelled without 48 hour notice. Your cooperation in canceling you 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.**

X\_\_\_\_\_ (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.

**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.**

X\_\_\_\_\_ (Please initial)

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.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us.

Thank you,

My signature below constitutes acknowledgement and acceptance of this policy.

Patient name:

\_\_\_\_\_

Patient or guarantor signature:

\_\_\_\_\_

Date: \_\_\_\_\_