Your appointment on _____ is at _____; however, we need you in the office 10 minutes early.

Please complete this paperwork and bring it with you to your appointment. Failure to do so may result in rescheduling your appointment. Thank you!

# Colorado Springs Dermatology Clinic, P.C.


**170 S. Parkside Dr.**
**Colorado Sprgs, CO 80910**
**P: (719) 471-1763**
**F: (719) 471-2498**

**2060 Briargate Prkwy Ste. 150**
**Colorado Sprgs, CO 80920**
**P: (719) 471-1763**
**F: (719) 471-2498**

**1332 Bauer Ln**
**Cañon City, CO 81212**
**P: (719) 275-7485**
**F: (719) 275-5331**

**406 N. Main St**
**Pueblo, CO 81003**
**P: (719) 566-0176**
**F: (719) 566-0177**

**Michael J. Babcock, MD, Seth Lofgreen, MD, PharmD, Cheryl L. Marcus, MD, Carole M. McClanahan, MD, MPH, Ginger S. Mentz, MD, Caitlin G. Robinson, MD, Patrick J. Sniezek, MD, Brian R. Sperber, MD PhD, Nathan S. Trookman, MD, Michael B. Turner, MD**

**Board Certified Dermatologists**


We are pleased that you have chosen our group of specialists for your skin care. We are sending this information to you ahead of time to make your visit to our office as convenient as possible. Our office hours are 8:00 am t 5:00 pm Monday thru Thursday and 8:00 am to 4:00 pm on Fridays for all location except for our Pueblo office which operates from 8:00 am to 2:00 pm on Friday's.

Patient Registration Forms: Please complete these forms before you arrive and bring them with you to your 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 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. You can email a digital copy of your card upon arrival. **If you do not bring your insurance card, you will be Self Pay for your visit.**

**Co-Payments:** These are the amounts that you have agreed with your insurance company to pay at each doctor's office visit. If you do not have the required co-payment with you, our agreement with your insurance company will force us to reschedule your appointment.

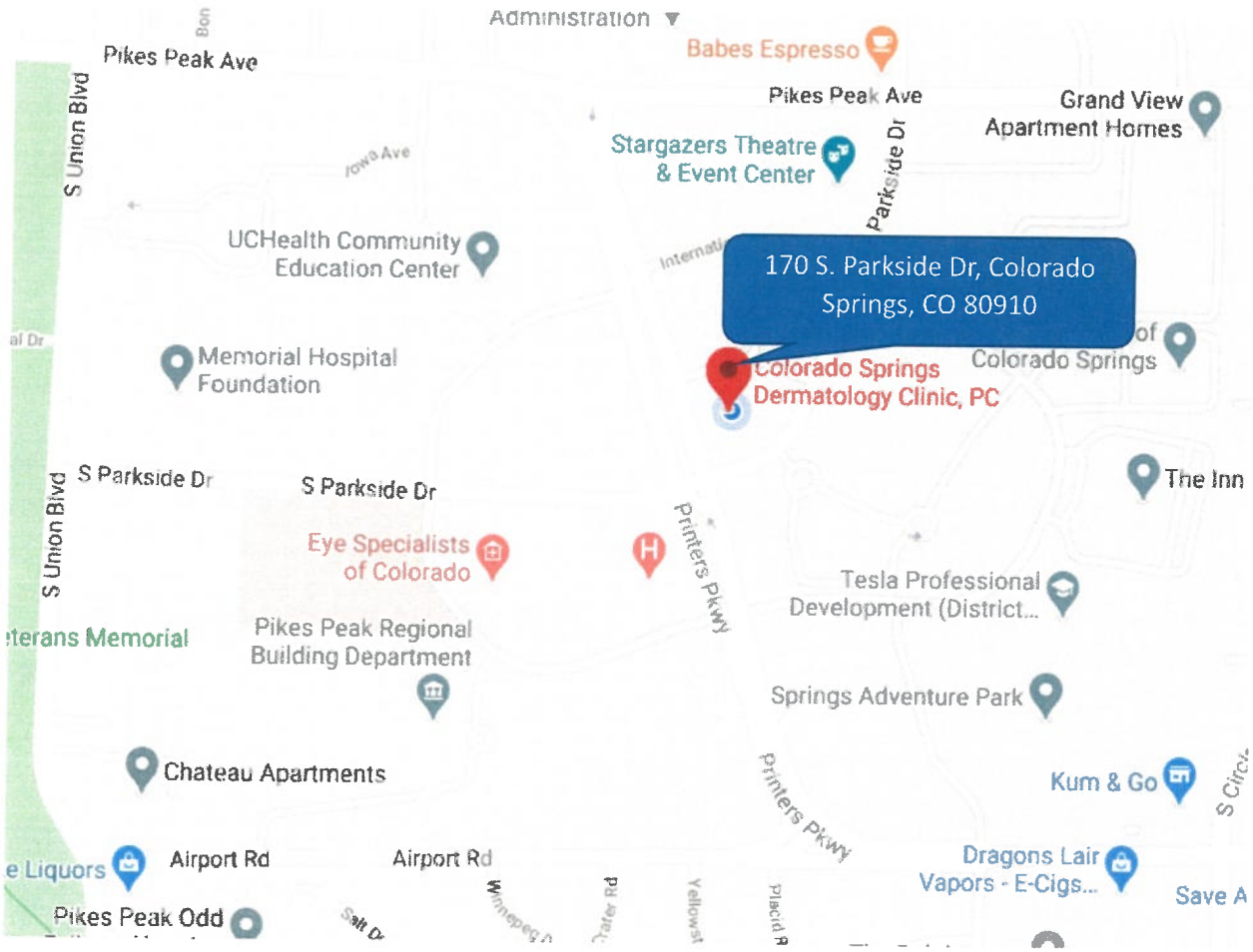
**Insurance Claims:** We will, for your convenience, submit your health claims using the insurance information that you have provided. If you change your insurance coverage, please be sure to let us know when you come in. Be aware that many insurance plans include deductible amounts that are also your responsibility. Please be prepared to pay these amounts at your next visit. Our billing department at (719) 471-1763 ext. 117 or 119 can answer questions regarding these amounts.

**Late or Missed Appointments:** We take great care in crafting the schedules of the doctors to accommodate as many people as possible. If you are late for your appointment, we will do our best to work you in when you arrive. Please call ahead and let us know if you will be late or need to reschedule your appointment by calling the clinic in which you are scheduled.

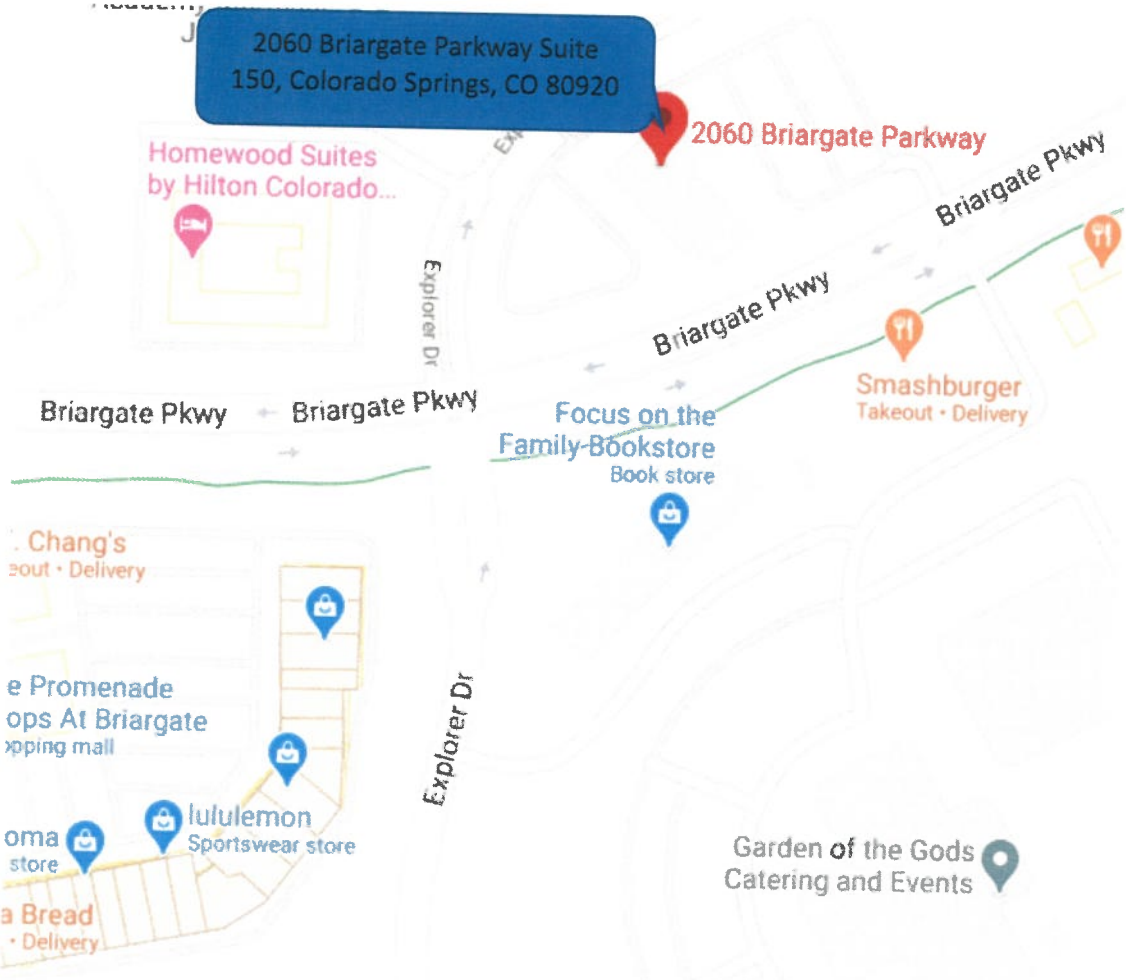
**Surgery:** Be sure to ask for any appropriate "after care" instructions to take with you for later reference. Also be aware that many insurance companies have separate surgery deductible amounts that you must meet. Pathology results will be communicated to you by telephone upon receipt from the laboratory,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

**Prescription Refills:** If you find yourself needing a refill of a prescribed medication, please call your pharmacy.

**Address: 170 S. Parkside Dr.**
**Colorado Springs, Colorado 80910**



**Address: 2060 Briargate Parkway, Suite 150**
**Colorado Springs, Colorado 80920**



**Colorado Springs Dermatology Clinic, P.C.**

Last Name: _____First Name: _____ MI: _____

**How would you like to be addressed?** _____

Address: _____

City: _____ State: _____ Zip Code: _____

SS#: _____-_____-_____Date of Birth: _____ Gender: M /F /OTHER

Home Number: (____) _____ Mobile Number: (____) _____

Email Address: _____

Primary Care Doctor. : _____ Referring provider: _____

**Name of Primary Insurance:** _____

**Policy Holder's Name:** _____ **Date of Birth:** _____

**Policy Holder's SSN#:** _____- _____ - _____ **Policy Number:** _____

**Group Name/Number:** _____

**Relationship to Patient:** □ **Self** □ **Spouse** □ **Parent** □ **Other**

**Name of Secondary Insurance if applicable:** _____

**Policy Holder's Name:** _____ **Date of Birth:** _____

**Policy Holder's SSN#:** _____- _____ - _____ **Policy Number:** _____

**Group Name/Number:** _____

**Relationship to Patient:** □ **Self** □ **Spouse** □ **Parent** □ **Other**

**Signature of Patient or Guardian:** _____**Date:** _____

Colorado Springs Dermatology Clinic, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

## Financial Policy and Authorization

**Patient Name:** _____ **DOB:**_____

Thank you for choosing Colorado Springs Dermatology Clinic. Our physicians and staff are committed to providing you with the best medical care. Please read this form carefully, as it outlines our policy regarding payment and authorization to file your medical insurance claim.

All patients should provide accurate and complete personal and insurance information prior to your appointment. It is the patient's responsibility to make sure that we have your most recent information. If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered. All applicable co-pays and any prior balances are due at the time of service.

Colorado Springs Dermatology Clinic has preferred provider contracts with most insurance companies. Your insurance coverage is a contract between you and your insurance company. Colorado Springs Dermatology Clinic is not responsible for services denied by your insurance company. It is to our advantage, as well as your responsibility, to know and understand your medical insurance coverage. It is also your responsibility to know if your insurance company requires a referral prior to your appointment.

**Financial Authorization:** I herby authorize my physician to bill my insurance company for services rendered. I also assign my physician any insurance payments for services provided to me. If these benefits are not paid to my physician, I agree to forward all health insurance payments I receive for services rendered to me immediately upon receipt. I am responsible for the payment of all charges for services rendered to the above patient. Payment will be made promptly, as bills are presented, with settlement in full or appropriate arrangements for settlement made.

The undersigned certifies that he/she read this document and that he/she is the patient or duly authorized as the patient's general agent to execute these consents and agreements and accepts these terms.

**Payments:** We accept cash, checks, Visa, MasterCard, Discover, American Express and upon approval Care Credit. Upon receipt of billing statements, outstanding balances are due within 30 days. Should your account become past due, it may be sent to a collection agency.

**Missed Appointments:** There is a $90 charge for missed surgical appointments to the Mohs Surgery Center. If you must cancel an appointment, please call, and let us know at least 24 hours prior to your appointment. After three no show occurrences, the practice may elect to terminate our relationship with you.

By signing below, you acknowledge you have carefully read, understand, and agree to the above terms.

Signed: _____Date: _____

Colorado Springs Dermatology Clinic, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

## Financial & Information Release:

**Use and disclosure of protected health information:** With my consent, Colorado Springs Dermatology Clinic (the practice) may use and disclose protected health information (PHI) or individually identifiable health information (IIHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Practice's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

**Prescription Drug Monitoring Database:** You may be given a prescription for a "controlled" (Schedule II through V) drug. Your identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Database (PDMP) when the drug is dispensed to you. Your prescription information in the database is a protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. You have the right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would your other medical records.

**Medicare Consent:** I certify that the information given by me in applying for payment under Title SVII and/or Title XIX of the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician services. I understand that I am responsible for my health insurance deductibles and the coinsurance and any co-payment amount.

**Payment for Service:** Payment is expected at the time of service; insurance co-payments are mandated by your insurance company and must be made today. I understand and agree that if my insurance carrier denies benefits for any reason including "not covered" or "cosmetic" I am responsible for the full amount for services provided. I request that payment be made to Colorado Springs Dermatology Clinic. In the event my account is turned over to a collection agency, I agree to pay all costs of collection. I understand and agree to pay a returned check charge of $40.00 per returned check.

Signature of PATIENT or GUARDIAN: _____ Date: _____

Colorado Springs Dermatology Clinic, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

# Colorado Springs Dermatology Clinic, P.C.

## Notice of Privacy Practices – Patient Acknowledgement

We at Colorado Springs Dermatology Clinic are committed to safeguarding the privacy and confidentiality of your medical records including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Authorization Form**

**Patient Identification**

**Patient Last Name:**_____ **First:**_____ **MI:**_____

**Date of Birth:**_____ **How would you like to be addressed?**_____

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

_____ **Home Phone:**_____

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

_____ **Work Phone:**_____

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

_____ **Cell Phone:**_____

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

Please list any family or other who may be involved in coordinating your care or payment for care. Also indicate what information may be shared with each individual.

| Name | Phone Number | Relationship to Patient | Type of Information | | |
|---|---|---|---|---|---|
| | | | All | Appts/Sched | Medical |
| | | | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ |

**Emergency Contact**

**Emergency contact:** _____ **Phone:**_____

**Relationship to Patient:**_____ **May we speak to this person regarding your care?** ☐ Yes ☐ No

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify our office if you wish to alter the designations above.

I have been made aware of the privacy policies of Colorado Springs Dermatology Clinic, P.C. that include Rocky Mountain Laser Center, P.C. and have received (or reviewed or been given the option to receive) a copy of the HIPAA Notice of Privacy Practices.

Signature of patient/Legal Representative:_____

Relationship to Patient:_____ Date: _____

Colorado Springs Dermatology Clinic, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. **Revised 10/14/2016**

COLORADO SPRINGS DERMATOLOGY CLINIC

**Patient Name:** _____ **DOB:** _____

**Primary Care Doctor:** _____ **If you were referred here provide doctor's name:** _____

**Preferred Language:** _____ **Race:** _____ **Marital Status** _____

**Ethnic Group:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ I choose not to specify

**Pharmacy name** _____ **address** _____ **phone** _____

**Past Medical History:** (please check all that apply)

| | | |
|---|---|---|
| ☐ Anxiety disorder | ☐ Disease caused by 2019-nCoV | ☐ Hypothyroidism |
| ☐ Arthritis | ☐ Elevated Blood Pressure | ☐ Inflammatory disease of the liver |
| ☐ Asthma | ☐ End Stage Renal Disease | ☐ Leukemia |
| ☐ Atrial Fibrillation | ☐ Epilepsy | ☐ Malignant Lymphoma |
| ☐ Benign Prosthetic Hyperplasia | ☐ GERD | ☐ Malignant tumor of breast |
| ☐ Cerebrovascular Accident | ☐ H/O Hypertension | ☐ Malignant tumor of colon |
| ☐ COPD | ☐ Hearing loss | ☐ Malignant tumor of prostate |
| ☐ Coronary Arteriosclerosis | ☐ HIV/AIDS | ☐ Radiation treatment |
| ☐ Depressive disorder | ☐ Hypercholesterolemia | ☐ Transplantation of bone marrow |
| ☐ Diabetes Mellitus | ☐ Hyperthyroidism | |

**Other:**

**Past Surgical History:** (please check all that apply)

| | |
|---|---|
| ☐ Abdominoperineal Resection | ☐ Hysterectomy |
| ☐ Bilateral replacement of knee joints | ☐ Kidney biopsy |
| ☐ Biopsy of breast (left, right, bilateral) | ☐ Low anterior resection of rectum |
| ☐ Biopsy of Prostate | ☐ Lumpectomy of breast (left, right, bilateral) |
| ☐ Coronary Artery bypass graft | ☐ Mastectomy of breast (left, right) |
| ☐ Entire transplanted kidney | ☐ Mechanical Valve replacement |
| ☐ Excision of Basal Cell Carcinoma | ☐ Oophorectomy |
| ☐ Excision of Melanoma | ☐ Pancreatectomy |
| ☐ Excision of Squamous Cell Carcinoma | ☐ Percutaneous extraction of kidney stones- fragmentation |
| ☐ H/O Colostomy | ☐ Portosystemic shunt operation |
| ☐ H/O Tubal Ligation | ☐ Prostatectomy |
| ☐ History of Appendectomy | ☐ Prosthetic arthroplasty of bilateral hips |
| ☐ History of Bilateral Mastectomy | ☐ Splenectomy |
| ☐ History of Cholecystectomy | ☐ Surgical biopsy of the skin |
| ☐ History of Colectomy | ☐ Total Nephrectomy |
| ☐ History of liver excision | ☐ Total Orchidectomy |
| ☐ History of PTCA | ☐ Total replacement of Hip (left, right, bilateral) |
| ☐ History of tissue graft heart valve replacement | ☐ Total replacement of knee joint (left, right) |
| ☐ History of total cystectomy | ☐ Transplantation of heart |
| ☐ History of transurethral prostatectomy | ☐ Transplantation of liver |

**Other:**

**Skin Disease History:** (please check all that apply)

| | | |
|---|---|---|
| ☐ Acne | ☐ Dysplastic nevus of skin | ☐ Pruritus of scalp |
| ☐ Actinic Keratosis | ☐ Eczema | ☐ Psoriasis |
| ☐ Asteatosis Cutis | ☐ H/O Asthma | ☐ Squamous Cell Carcinoma |
| ☐ Basal Cell Carcinoma | ☐ H/O hay fever | ☐ Sunburn of second degree |
| ☐ Contact Dermatitis due to poison Ivy | ☐ Malignant Melanoma | |

**Other:**

**DO YOU WEAR SUNSCREEN?** ☐ YES ☐ NO

*If yes, what SPF:* _____

**DO YOU TAN IN A TANNING SALON?**

☐ YES ☐ NO

**HEIGHT:** _____ **WEIGHT:** _____

**DO YOU HAVE A FAMILY HISTORY OF MALIGNANT MELANOMA?**

☐ YES ☐ NO

*If yes, which relative(s):* _____

**MEDICATIONS** (please list all current medications including the dose and frequency):

_____ _____

_____ _____

_____ _____

_____ _____

☐ NO MEDICATIONS

**DRUG ALLERGIES** (please list all known allergies and reactions):

_____ _____

_____ _____

☐ NO KNOWN DRUG ALLERGIES

**SOCIAL HISTORY:**

**Smoking status:** ☐ Current every day smoker ☐ Current someday smoker
Date you started smoking _____ Date you quit smoking_____
☐ Former smoker ☐ Never smoker

**Alcohol use:** ☐ None ☐ < 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day
**Male patient:** How many times in the past year have you had 5 or more drinks in a day?_____
**Female patient:** How many times in the past year have you had 5 or more drinks in a day?_____

**Occupation:** _____

| **ALERTS:** (please circle all that apply) | | |
|---|---|---|
| ☐ Allergy to adhesive | ☐ Artificial joint replacement | ☐ MRSA |
| ☐ Allergy to latex | ☐ Blood thinners | ☐ Pacemaker |
| ☐ Allergy to lidocaine | ☐ Defibrillator | ☐ Require antibiotics prior to procedure |
| ☐ Artificial valve replacement | ☐ Keloid scarring | ☐ Rapid heart beat with epinephrine |

**ARE YOU PREGNANT OR CURRENTLY TRYING TO GET PREGNANT?** ☐ YES ☐ NO
**HAVE YOU HAD A FLU SHOT THIS SEASON?** ☐ YES ☐ NO **DATE RECEIVED**_____
**HAVE YOU EVER HAD A PNEUMONIA SHOT?** ☐ YES ☐ NO

**REVIEW OF SYSTEMS:** Are you currently experiencing any of the following? (Please check yes or no)

| Symptom | Yes | No |
|---|---|---|
| Are you in generally good health? | | |
| Do you have problems with bleeding? | | |
| Do you have problems with healing? | | |
| Do you have problems with scarring? | | |
| Do you currently have a rash? | | |
| Do you have any new skin lesions? | | |
| Do you have any changing skin lesions? | | |

**PATIENT SIGNATURE:**