

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.**

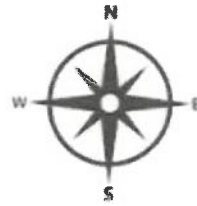
**Co-Payments:** These are the amounts that you have agreed with your insurance company to pay at each doctor's office visit. If you do not have the required co-payment with you, our agreement with your insurance company will force us to reschedule your appointment.

**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.

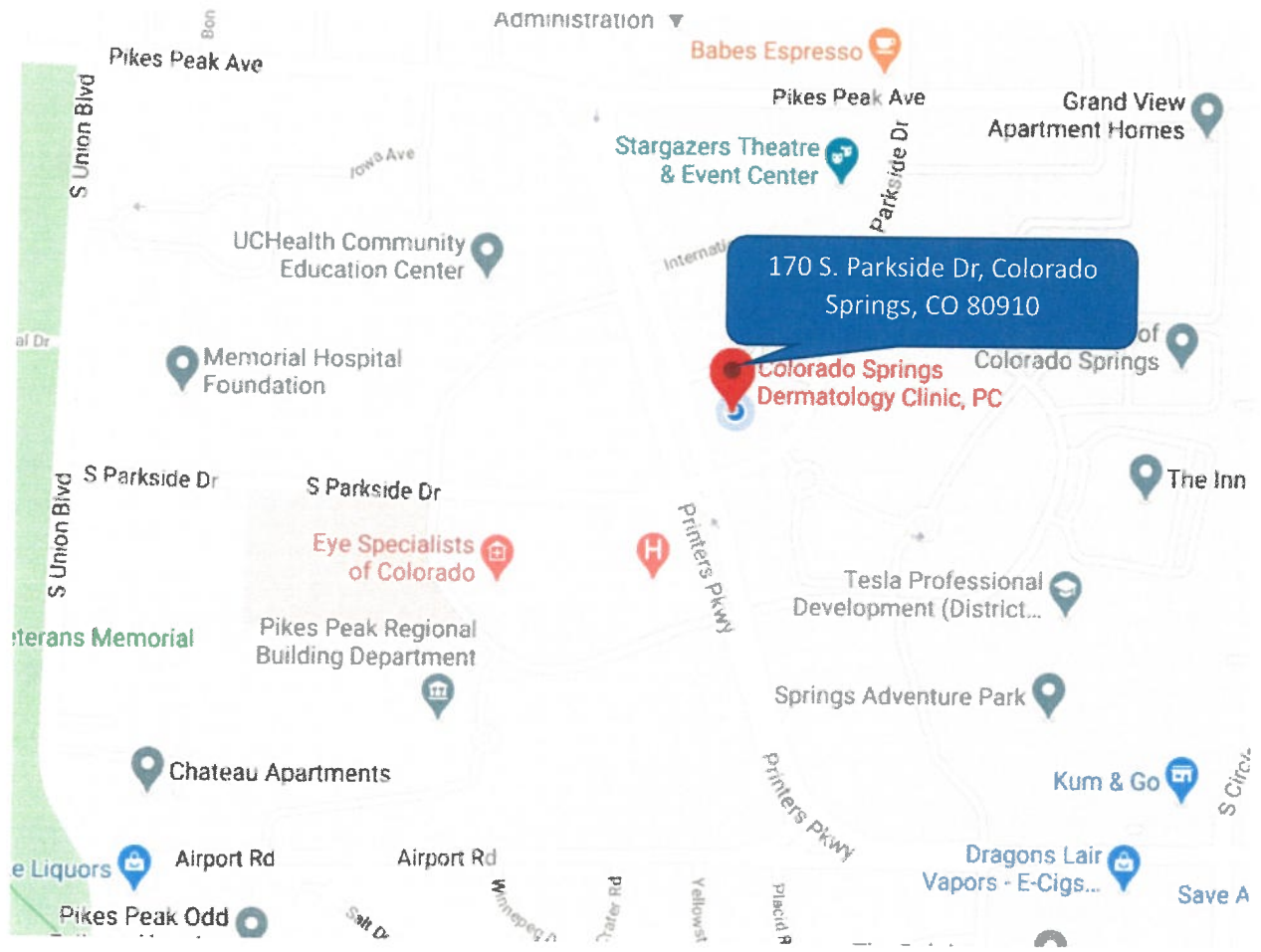
**Late or Missed Appointments:** We take great care in crafting the schedules of the doctors to accommodate as many people as possible. If you are late for your appointment, we will do our best to work you in when you arrive. Please call ahead and let us know if you will be late or need to reschedule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

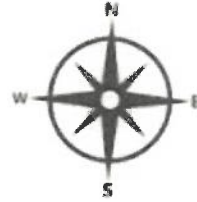
**Surgery:** Be sure to ask for any appropriate "after care" instructions to take with you for later reference. Also be aware that many insurance companies have separate surgery deductible amounts that you must meet. Pathology results will be communicated to you by telephone upon receipt from the laboratory,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

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

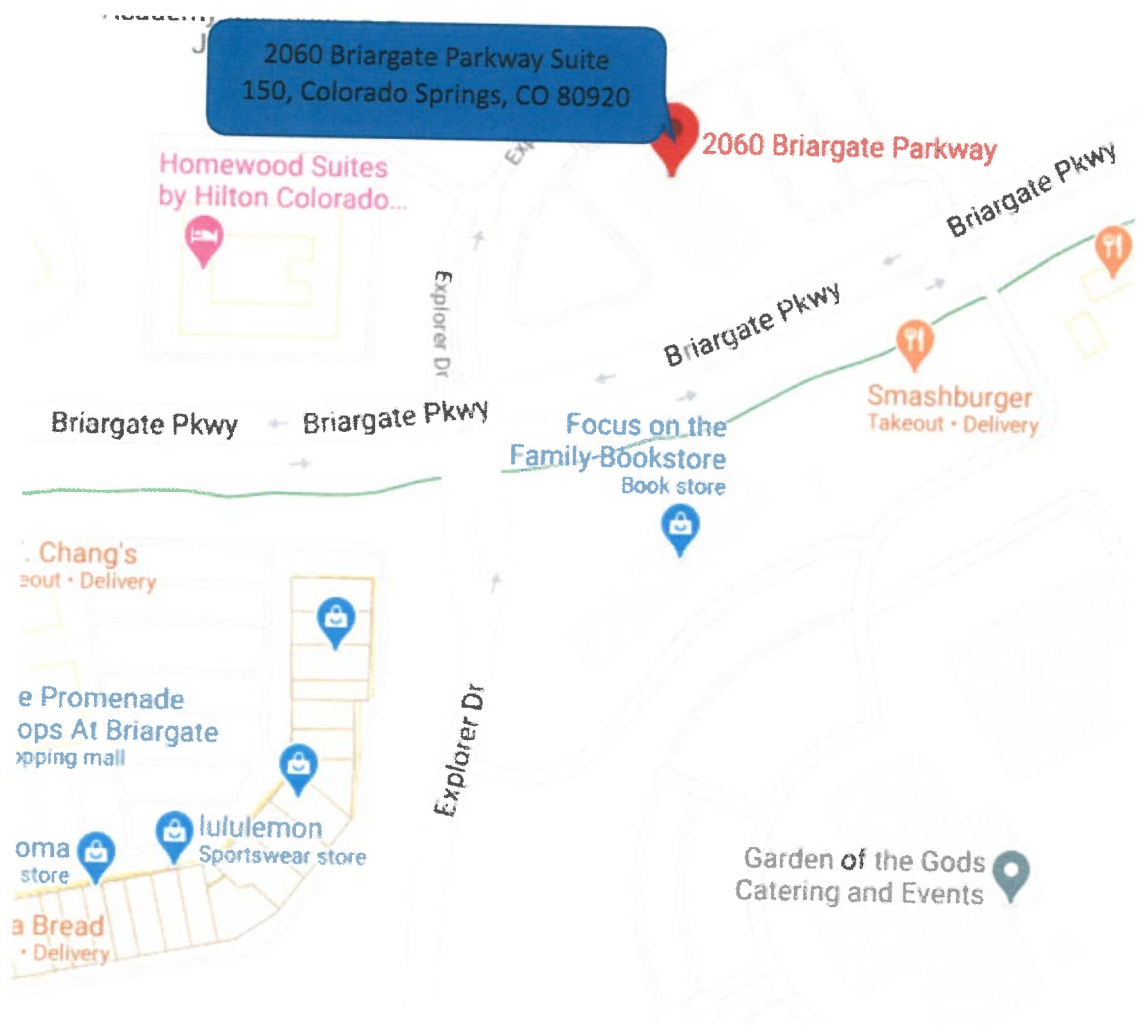


**Address: 170 S. Parkside Dr.  
Colorado Springs, Colorado 80910**





**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: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_

<p><b>Name of Primary Insurance:</b> _____</p> <p><b>Policy Holder's Name:</b> _____ <b>Date of Birth:</b> _____</p> <p><b>Policy Holder's SSN#:</b> _____ - _____ - _____ <b>Policy Number:</b> _____</p> <p><b>Group Name/Number:</b> _____</p> <p><b>Relationship to Patient:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other</p>
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<p><b>Name of Secondary Insurance if applicable:</b> _____</p> <p><b>Policy Holder's Name:</b> _____ <b>Date of Birth:</b> _____</p> <p><b>Policy Holder's SSN#:</b> _____ - _____ - _____ <b>Policy Number:</b> _____</p> <p><b>Group Name/Number:</b> _____</p> <p><b>Relationship to Patient:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other</p>
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**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.