IDAHO SKIN INSTITUTE

147 W Chubbuck Rd·Chubbuck, ID 83202
Clinic: 208-238-SKIN (7546)·Fax: 208-237-9643

PATIENT INFORMATION

Name (Last, First, Initial)_____Date_____
Social Security Number_____Date of Birth _____Sex [M] [F]
Mailing Address _____City, State, Zip_____
Race: [ ]-White [ ]-Hispanic [ ]-Black [ ]-American Indian [ ]-Asian Preferred Language: [ ] English or Other_____
Marital Status: [ ]-Married [ ]-Single [ ]-Other [ ]-Widow [ ]-Separated [ ]-Divorced
Referred By_____
Home Phone_____Work Phone_____Cell Phone_____
E-mail Address:_____
Employment Status: [ ]-Full Time [ ]-Part Time [ ]-Retired [ ]-Unemployed [ ]-Full Time Student [ ]-Part Time Student
Employed By:_____Employer Phone:_____
Spouse/Parent's Name_____Date of Birth_____
Emergency Contact_____Relationship_____Phone# _____
(not living with you)

PRIMARY RESPONSIBLE PARTY

(Statements will be sent to this person)

Name (Last, First, Initial)_____Relationship_____
Mailing Address_____City, State, Zip_____
Home Phone_____Work Phone_____Cell Phone_____
*Social Security Number_____Sex_____Date of Birth_____
Employed By:_____Employer Phone:_____

INSURANCE INFORMATION

We are contracted with: Blue Cross, Blue Shield, DMBA, IHC, Medicaid, Medicare, SIPHO/MRI, Beech Street, IPN, and UPREHS
For accurate billing to insurance, we will request a copy of your insurance card for our files.

Primary Insurance_____ Policy Holder's Name _____
Policy Holder's Date of Birth_____Sex_____ Employer_____
Group #:_____ Policy# _____
Secondary Insurance _____Policy Holder's Name_____
Policy Holder's Date of Birth_____ Sex_____ Employer_____
Group #:_____ Policy #:_____

ASSIGNMENT AND RELEASE:

Please **initial** next to the line that is appropriate

Initial Below

_____**NON MEDICARE**: I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I authorize the physician to release any information required to process my claim.

_____**MEDICARE**: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Idaho Skin Institute for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

AUTHORIZATION/ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (name of patient)_____, acknowledge and agree that I have read a copy of Idaho Skin Institute's Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Date

IDAHO SKIN INSTITUTE MEDICAL HISTORY
History and Intake Form

Referring/Primary Care Physician: _____

NAME:_____DATE OF BIRTH:_____DATE:_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Knee Replacement (Right, Left, Bilateral)
Hip Replacement(Right, Left, Bilateral)
Joint Replacement (within last 2years)
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Cancer Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None
Other _____

Women ONLY: (please circle all that apply)

Currently Pregnant
Breast Feeding
Hysterectomy:
- Fibroids
- Uterine Cancer

Ovaries Removed:
- Endometriosis
- Ovarian Cancer
- Ovarian Cyst

Oral Contraception
Tubal Ligation
Post-Menopausal
Frequent Yeast Infections
Other _____

Do you currently have/take any of the following? (Please check yes or no for the following)

Review of Symptom	Yes	No
Abdominal pain		
Joint aches		
Muscle weakness		
Headaches		
Depression		
Unintentional weight loss		
Shortness of breath		
Seizures		
Chest pain		
Rash		
Fever/chills		
Cough		
Problem with bleeding		
Problem with healing		
Hay fever		
Night sweats		
Thyroid problems		
Anxiety		
Anemia		
Other		

Alert	Yes	No
Pacemaker/Defibrillator		
Defibrillator- OK with magnet		
Bad reaction to Novacaine		
Artificial joint		
HIV		
Hepatitis B		
Hepatitis C		
Coumadin		
Plavix		
Prophylactic antibiotics (antibiotics needed before dental work)		
Allergy to adhesive		
Allergy to topical antibiotics		
Allergy to Latex		
Organ Transplant		
Large scars/keloids		
Immunosuppression		
History of radiation		
Currently Pregnant		
Other		

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)

_____
_____

Allergies: (Please enter all allergies)

_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
YES
NO

Height: _____
Weight: _____

Pharmacy: Name: _____
Street:_____ Zip Code: _____

Idaho Skin Institute Financial Policy

PAYMENT RESPONSIBILITY - - - Insurance including MEDICARE

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While the clinic will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the rates and terms of the clinic in effect at the time of service. Please keep in mind you are responsible to provide us with correct and current insurance information and to notify us of any change in your address or telephone number. **Initial**____

COPAYS & DEDUCTIBLES

All copays/deductibles are due at the time of service. We accept: Cash, Check, VISA, Master Card, American Express, Discover & FSA/HSA cards. If you are having surgery, your estimated portion, including any deductibles, is expected at the time of service. You may not receive a self-pay discount and then file with your insurance at a later date. You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either fully or partially) by your insurance. For convenience, a credit card may be left on file for future payments. If you would like to use this option, please let us know. **Initial** ____

NON-INSURED and/or OUT OF NETWORK INSURANCE:

If you are unable to present your insurance information at the time of service or if you are covered by an insurance with which we are not contracted (aka out of network), you are required to pay

- a deposit of **$250.00** due at the time of your office visit.
- A deposit of **$1500.00** due prior to any surgery. **Initial** ____

REFERRALS:

If your insurance requires you to have a referral to see a specialty clinic, it is your responsibility to contact your primary care provider to obtain the referral. The referral must be current prior to your scheduled visit. If you choose to be seen without a current referral, you will be personally responsible for all charges incurred for that/those visit(s). **Initial** ____

Cosmetic Procedures & Retail Products

Cosmetic procedures & purchase of retail products are elective services & purchases that are not covered by insurance. Payment in full for these services & products is due at the time of service and purchase. If you receive both elective (non-covered) and medically necessary (covered) services on the same day, you will be responsible for full payment of the elective services and full payment of any copays and unmet deductibles for the medical services. **Initial** ____

Minor Patients

A parent/guardian who brings a minor to our office for care is responsible for payment of all of the minor's charges including the copay each time the minor is seen. Unaccompanied minors will be denied non-emergency treatment unless pre-authorized by parent or guardian. If a minor needs to be seen & a parent/guardian is not able accompany them an *Authorization for Treatment of Minor* form must be signed prior to appointment. This form can be obtained in office or on our website. **Initial** ____

Our Administration Fees:

- A $25 fee is charged for missed appointments.
- A $200 will be charged for a missed surgery appointment.
- A $35 fee is charged for returned checks. **Initial** ____

Outside Pathology & Lab Fees

Skin biopsy and lab samples sent outside of our office are billed separately from the office visit. We are not able to give quotes on the cost of these studies as sometimes additional testing on these samples is needed. Your insurance and/or you will be billed separately for these services. If you have had any of these studies performed, you may have additional pending charges above & beyond what you paid today.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or any dependent) by The Idaho Skin Institute. By signing this document, I agree that I want ISI to submit insurance billable charges to my insurance and I agree to pay any and all remaining charges. By signing, I attest to having read and understood this financial policy and agree to its terms.

PATIENTS NAME: _____ **SIGNATURE OF PATIENT OR RESPONSIBLE PARTY**

PATIENTS DATE OF BIRTH: _____ _____

Printed Name _____

IDAHO SKIN INSTITUTE

Authorization for Release of Information

Patient Name:_____ Date of Birth:_____

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will only give information to the people indicated below.

I give permission to contact the below individuals regarding fee estimates for medical equipment and/or surgical procedures in the event I can not be contacted: ☐ **YES** ☐ **NO**

I give permission for Idaho Skin Institute to obtain medication lists from their pharmacy and insurance:

☐ **YES** ☐ **NO**

I authorize Idaho Skin Institute to release my medical and/or billing information to the following individual(s):

1. Name:_____

   Relation to Patient:_____ Phone Number_____

2. Name:_____

   Relation to Patient:_____ Phone Number_____

3. Name:_____

   Relation to Patient:_____ Phone Number_____

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:_____ **Date:** _____