Welcome to Skin MD Dermatology and Skin Enhancement Center. We look forward to seeing you soon at you upcoming appointment. Address: 640 Southpointe Court, Suite 110, Colorado Springs,CO 80906 Phone: (719) 228-9488

Be prepared for your visit:

1) Bring your ***insurance card*** with you. If you do not bring your insurance card, you will be charged as a "Self Pay" or uninsured patient.
2) Please bring copy of ***your referral*** with you. If you have HMO insurance, Tricare Prime or Triwest (VA), YOU are responsible for obtaining a referral from your Primary Care Provider. If you don't have your referral, you will be responsible to pay for your visit as a "Self Pay" or uninsured patient.
3) Bring these ***COMPLETED forms*** with you
4) Please bring a list or a photo of all of *your medications,* especially those that you have used to treat your skin complaint.
5) ***Co Payments***: These are the amounts that you have agreed with your insurance company to pay at each medical visit. We have a contractual agreement with your insurance to collect this.
6) DO NOT WEAR foundation-type make up or tinted creams to your appointment. Eye make up is OK unless you have an eye issue that we are evaluating – we need to see your skin!
7) Your appointment is reserved for you. If your family members have any concerns, they will need their own separate appointment.
8) If you are under 18 years old, you will need to have parent or guardian present for your visit.
9) Late or missed appointments: If you are late, we will do our best to work you into the schedule as space allows or you may be asked to reschedule your appointment. A "no show" fee may be assessed if you miss your appointment.
10) PLEASE BRING A FACE MASK

Notice of Patient Privacy: We at Skin MD Dermatology and Skin Enhancement Center 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 (HIPPA) Use and disclosure of protected health information. Skin MD Dermatology Providers use and disclose protected health information or individually identifiable health info about me to carry out treatment, payment and healthcare operations including releasing information about my diagnosis and treatment to my primary care or other referring physicians. Please notify the front desk staff if you would like a copy of our HIPPA policy to review.

We look forward to seeing you and appreciate the opportunity to serve you. Thank you for your cooperation in preparing for your visit with us. Please sign below to indicate that you have read and understand this letter.

Signature: ____________________________________ Date: ___________________________________

Skin MD Dermatology and Skin Enhancement Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, sex, sexual orientation or disability.

Financial Policy and Authorization

Patient Name:____DOB:_______________

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. It is ***your*** responsibility to know if your insurance company requires a referral prior to your appointment.

Payment for Services: Insurance co-payments are mandated by your insurance company and must be paid today. It is ***your*** responsibility to pay health insurance deductible and co-insurance payments in addition to co-payments. Be aware the some insurance plans have separate deductibles for surgical procedures. I understand and agree that if the insurance company denies benefits for any reason, I am responsible for the full amount of services provided. I understand that the definition of the "non-covered" or "cosmetic" is made solely by my insurance company. ***Skin MD Dermatology is not responsible for services denied by your insurance company***.

Balances are due within 30 days. I understand that if my account becomes past due, it may be sent to a collections agency and I agree to pay all costs of collections. I understand and agree to pay a returned check fee of $50 per returned check for any reason.

Financial Authorization: I hereby authorize my physician/provider to bill my insurance company for services rendered. I also assign my provider any insurance payments for services provided to me. 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

Medicare only: I certify that the information given to/by me in applying for payment under Title SVII and/or TITLE XIX of the Social Security Administration or its intermediary carriers is accurate and to provide any information necessary for this or related Medicare claims. I request that payment of my benefits be made on my behalf and I assign the benefits payable for the provider services.

Late Policy: A patient arriving more than 10 minutes after the scheduled appointment time will be considered tardy. The team at Skin MD will make every attempt to accommodate late patients *based on schedule availability* and at the discretion of the provider. Please call ahead if you know you will be late .

No Show Policy: Each time a patient misses an appointment without providing notice there is a loss of 3 patient visits. The "missed" appointment is lost to the patient who "no showed" and to a patient who could have benefited from that appointment. Then, when the patient who "no showed" books a future appointment, there is a third office appointment consumed. Therefore, Skin MD Dermatology and Skin Enhancement Center reserves the right to charge a fee of $50.00 for missed appointments ("no-shows"). Patients are to call at least 24-hours in advance and inform our office if they cannot make the scheduled appointment. No show fees will be billed to the patient and **are not covered by insurance**. Multiple "no shows" may results in requirement to pre-pay for our services or in termination from our practice.

Patients who have purchased a series of treatments and fail to provide 24 hours notice, will be subject to the loss of one treatment in their series. Thermage or Fraxel patients must provide 48-hour notice of cancellation or will forfeit their reservation deposit.

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.

Patient or Patient/Legally authorized representative signature: ___________________________________

Printed Name and Relationship to patient:_____________________________________Date:___________

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Colorado Springs, CO 80906
719-228-9488 www.skinmdcolorado.com

SKIN MD DERMATOLOGY AND SKIN ENHANCEMENT CENTER

LAST NAME: _____________________________ FIRST NAME:_________________________MI:____

ADDRESS: ____CITY:________________ ST: _____ ZIP:________

SSN#____-____-______ DATE OF BIRTH: ________________ GENDER: _________________

EMAIL: __________________________________ EMPLOYER:____

CELL PHONE: _____________________ May we leave a message on this phone? YES / NO

HOME PHONE: ____________________ May we leave a message on this phone? YES / NO

WORK PHONE: ____________________May we leave a message on this phone? YES / NO

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 person (ie: all medical information or just appointments)

Name	Phone	Relationship to Patient	Type of Information
__________________________	_____________	___________________	◯ All ◯Appointments only
__________________________	_____________	___________________	◯ All ◯Appointments only
__________________________	_____________	___________________	◯ All ◯Appointments only

EMERGENCY CONTACT: if listed above, please circle name **OR** Name: ______________________________ Ph: ________________

May we speak to this person regarding your care? ◯ Yes ◯ No

PRIMARY CARE PROVIDER: Name___________________ Phone:_____________ Practice Name and City:________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ◯REFERRED HERE BY A MEDICAL PROVIDER? IF SO, WHO________________________________

◯INTERNET ◯INSURANCE COMPANY DIRECTORY ◯FRIEND/FAMILY _______________◯Other ____________

NAME OF PRIMARY INSURANCE: ____

Policy Holder's Name:____ Date of Birth: __________________________

Policy Holders's SSN: ____-______-_____ Policy Number: ___________________________________

Group Name/Number: ____

Relationship to Patient: □ self □ spouse □ parent □ other

NAME OF SECONDARY INSURANCE: ____

Policy Holder's Name:____ Date of Birth: __________________________

Policy Holders's SSN: ____-______-_____ Policy Number: ___________________________________

Group Name/Number: ____

Relationship to Patient: □ self □ spouse □ parent □ other

Signature of Patient or Guardian: ____ **Date**: _______________________

Skin MD complies does not discriminate on the basis of race, color, national origin, age, disabilitiy sex or sexual orientation

Cosmetic Information and History

Name: ______________________________ DOB: ____________________ Today's Date: _________

What specific areas are you looking to improve? Circle all that apply

Brown Spots/Pigment Issues
Frown Lines/Forehead Lines
Body shape
Saggy skin
Jowls
Neck

Crow's Feet
Redness or Blotchiness
Skin Wrinkles
Skin Texture
Thin Lips/Lip Lines
Chest Discoloration

Facial Blood Vessels
Small or Double Chin
Scars
Skin tags
Skin growths
Other:____________________

Which of the following best describes your skin? (Circle one)

I. Always burn, never tan (lightest white)
II. Always burn, eventually tan (fair)
III. Sometimes burn, easily tan (medium white skin)
IV. Rarely burns, always tan 9dark olive, Asian, Hispanic, Mediterranean)
V. Brown/Light Black
VI. Very Black

What products do you currently use?

AM________________________________
____
____
____

PM________________________________
____
____
____

What cosmetic treatments have you had in the past?

____
____
____
____

What are your current medications?

____
____
____
____

What are your allergies?

____
____
____
____

What are your major medical problems?

____
____
____

Are you:

☐ pregnant/breastfeeding?
☐ on blood thinners?
☐ prone to fainting?
☐ prone to herpes/cold sores?
☐ pacemaker/defibrillator?
☐ sensitive to light?
☐ prone to keloid?

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