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 <u>you</u> 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.

SkinMD Dermatology and Skin Enhancement Center
640 Southpointe Court, Suite 110
Colorado Springs, CO 80906
719-228-9488 www.skinmdcolorado.com

skinMD
Dermatology and Skin Enhancement Center
Elizabeth Piantanida, MD Sarah Jenik DNP, FNP-C

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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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

MEDICAL HISTORY FORM

Patient Name:_____ Date of Birth :_____ Primary Language:_____

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

Pharmacy Name: _____ Address:_____

PAST MEDICAL HISTORY :		
□Anxiety disorder	□Diabetes - Type 1 or Type 2	□High Cholesterol or Triglycerides
□Arthritis	□Covid 19 associated condition	□Inflammatory Bowel Disease
□Asthma	□Coronary atherosclerosis	□Hyperthyroid or Hypothyroid
□Artificial joints	□Heart Valve disease	□Liver Disease
□Atrial Fibrillation	□Stroke	□Leukemia
□Autoimmune disease_____	□Hay Fever/Allergic Rhinitis	□Lupus
□Benign Prostatic Hyperplasia	□End Stage Renal Disease	□Lung Cancer
□Bleeding Disorder	□Epilepsy/seizures	□Prostate Cancer
□Bone Marrow Transplant	□GERD (GI reflux)	□Lymphoma
□Breast Cancer	□Hearing Loss	□Pacemaker/defibrillator
□Colon Cancer	□Herpes Simplex/Cold Sores	□Cerebrovascular Accident (stroke)
□COPD/Emphysema	□Hepatitis	□Cancer (other than skin)
□Coronary Artery Disease	□Hypertension/High Blood Pressure	_____
□Depression	□HIV	□Radiation treatment _____
		□**NO KNOWN MEDICAL PROBLEMS**
OTHER:		

PAST SURGICAL HISTORY:	
□Appendix removed	□Prostate removed : Prostate Cancer
□Bladder removed	□Prostate biopsy or TURP
□Mastectomy (Right, Left, bilateral)	□Kidney biopsy or kidney removed
□Lumpectomy	□Kidney Stone removal
□Breast Biopsy	□Kidney Transplant
□Breast Reduction or Implant (circle)	□Splenectomy (spleen removal)
□Colectomy: Colon Cancer Resection	□Orchidectomy (testicles removed)
□Colectomy: Diverticulitis	□Vasectomy
□Colectomy: Inflam. Bowel Disease	□Hysterectomy? Why? _____
□Gallbladder Removed	□Lung surgery_____
□Cerebrovascular Accident (stroke)	□Transplant (other): _____
□ Coronary Artery Bypass	□Liver_____
□ Artificial Heart Valve (mechanical or biological)	□Lung Cancer
□ PTCA (angioplasty)	□Skin Biopsy
□Heart Transplant	□Skin Surgery (circle below)
□Joint Replacement: Hip (L/R) Knee (L/R) Other:	Melanoma Basal Cell Cancer Squamous Cell Cancer Other
Within past 2 years? □Yes □No	□Cosmetic Surgery:_____
□Tubal Ligation	_____
□Ovaries removed? Why? _____	OTHER: _____
	_____

PRESCRIPTION MEDICATIONS:_____

_____

_____

□ **I TAKE NO PRESCRIPTION MEDICATIONS**

OVER-THE-COUNTER MEDS:_____

ALLERGIES:_____

□ **I HAVE NO KNOWN DRUG ALLERGIES**

SKIN DISEASE HISTORY:

☐ Acne	☐ Eczema	☐ Basal Cell Carcinoma
☐ Actinic Keratosis (precancerous)	If yes, Asthma? ___ Hay Fever __	Site(s): _____
☐ Atypical/Dysplastic moles	☐ Herpes Simplex	☐ Squamous Cell Carcinoma
☐ Chicken Pox	☐ Itching	Site(s): _____
☐ Contact Dermatitis	Location? _____	☐ Melanoma
☐ Dry Skin (Asteatosis)	☐ Seborrheic Dermatitis	Site(s): _____ Year_____
	Sunburn of second degree	

Family History of Melanoma? □Yes □No If yes, which relative(s)? _____
Do You Wear Sunscreen? □Yes □No If yes, what SPF? _____
Do you/have you tanned in a TANNING BED? □Yes □No

SOCIAL HISTORY:

OCCUPATION:_____

SMOKING: □NEVER SMOKER □ CURRENT SMOKER □ FORMER quit date: _____

ALCOHOL USE: □ NONE □ < 1 DRINK/DAY □ 1-2 DRINKS/DAY □ 3 OR MORE DRINKS/DAY

How many times in the past year have you had 5 or more drinks in a day? _____

ALERTS:

Pregnant or trying? □Yes □No

Have you had: Flu vaccine? □Yes □No Date of last dose: _____ mo/yr
Covid vaccine? □Yes □No Date of last dose:_____mo/yr
Pneumonia vaccine? □Yes □No Date of last dose:_____mo/yr
Shingles vaccine? □Yes □No (Shingrix / Zostavax / unsure)

ALERTS: (please check all that apply)		
□Allergy to adhesive	□Artificial Joint replacement	□MRSA
□Allergy to latex	□Blood Thinners	□Pacemaker
□Allergy to lidocaine	□Defibrillator	□Require Antibiotic before procedures
□Artificial heart valve replacement	□Keloid Scars	□Rapid heart beat with epinephrine

REVIEW OF SYSTEMS	YES	NO
Are you in general good health?		
Problems with bleeding/blood thinners?		
Problems with healing?		
Problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		