



DERMATOLOGY BY SHELLY

NAME: _____ TODAY'S DATE ____/____/____

HOW DID YOU HEAR ABOUT US? _____

DOB: ____/____/____ SEX: MALE___ FEMALE___ NON-BINARY___

RACE: AMERICAN INDIAN___ BLACK___ WHITE___ ASIAN___ HISPANIC/LATINO___
OTHER _____

MARITAL STATUS: Married___ Single___ Divorced___ Widowed___

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SECONDARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____ HOME PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ RETIRED: _____

WORK PHONE: _____ NOT EMPLOYED _____

SOCIAL SECURITY # _____ (REQUIRED FOR MEDICARE)

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____

IS THERE ANYONE WE ARE ABLE TO SHARE YOUR HEALTH INFORMATION WITH:

NAME: _____ RELATIONSHIP: _____

PHONE # _____

All Information can be shared _____ Only The Information Stated Below May Be Shared

NAME: _____ DOB: _____ / _____ / _____

MEDICAL INFORMATION

Please give insurance cards, guarantor information and driver's license to the front staff if not already done so.

SELF PAY/ NO INSURANCE: _____

Primary Insurance: _____ Secondary Insurance: _____

Please give cards and proper identification to the front desk if you have not done so already

Primary Care Provider _____ Name of Practice _____

Phone # _____

Referring Provider (If different) _____ Name of Practice _____

Phone # _____

PREFERRED PHARMACY NAME & STREET _____

REASON FOR VISIT TODAY: _____

FYI: IF YOU ARE HERE FOR SKIN CHECK, HAIR LOSS OR RASH YOU MAY NEED TWO SEPARATE APPOINTMENTS AS SOMETIMES THESE VISITS CAN TAKE QUITE SOME TIME. YOUR PROVIDER WILL DO THEIR BEST TO ACCOMODATE YOU.

MEDICATION ALLERGIES OR SENSITIVITIES AND THE REACTION: NONE _____

1) _____ / _____ 2) _____ / _____

3) _____ / _____ 4) _____ / _____

5) _____ / _____ 6) _____ / _____

MEDICATIONS:

Do you consent to Dermatology & Skin Care by Shelly transferring medication from the pharmacy database, if available?

Yes _____ No _____

We ask that you provide a list of medications on the following page for our review. If you have a list that you carry, we would be happy to take a copy with your consent.

NAME: _____ DOB: _____ / _____ / _____

MEDICATIONS (Including Vitamins and Supplements)

Please list or provide a list of all medications. Please understand that certain medications may be contraindications to specific treatments or procedures. We rely on the accuracy of the information you provide to deliver safe and effective care.

NONE _____

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10) _____

11) _____

NAME: _____ DOB: _____ / _____ / _____

HISTORY OF SKIN CANCER

- BCC
- SCC
- MELANOMA
- MERKEL CELL
- LYMPHOMA
- FAMILY HISTORY OF MELANOMA
- OTHER _____

Do you wear sunscreen/sunblock? Yes ___ No ___

PLEASE CHECK ANY HISTORY OF THE FOLLOWING

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hypertention	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Arthritis	<input type="checkbox"/> End-Stage Renal Disease	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> MRSA
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Defibrillator
<input type="checkbox"/> A-Fib	<input type="checkbox"/> GERD	<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Prostatic Hyperplasia	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Eczema
<input type="checkbox"/> CVA	<input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroid

Neurological Disorders

(Alzheimer's, Amyotrophic Lateral Sclerosis (ALS), Brain Tumors, Epilepsy, Seizures, Cerebral Aneurysm, Bell's Palsy etc.)

Musculoskeletal Disorders

(Osteoarthritis, Rheumatoid arthritis, Gout, Osteopenia, Spondyloarthritis, Sarcopenia, etc.)

Autoimmune Disorder

(IBD, RA, Lupus, Type 1 Diabetes, MS, Scleroderma, Psoriasis, Psoriatic Arthritis, Gullain-Barre Syndrome, Chronic Inflammatory Demyelinating Polyneuropathy, Myasthenia Gravis, Thyroid Dz, Vasculitis etc.)

OTHER: _____

NAME: _____ **DOB:** _____ / _____ / _____

PLEASE CIRCLE THE ANSWER THE FOLLOWING QUESTIONS:

What is your smoking status? Current | Former | Never |

If you are a current smoker, how many packs a day do you smoke? _____

Do you consume alcohol? Yes | No |

If yes, how much? Less than 1 drink / day | 1-2 drinks / day | 3 or more drinks / day |

For Patients 66 and Older:

Have you received the pneumonia vaccine? Yes | No |

Do you have a healthcare proxy in the event you cannot make your own medical decisions? Yes | No |

Do you have a living will? Yes | No |

PLEASE REVIEW AND SIGN CONSENT FORMS FOLLOWING THIS PAGE

NAME: _____ **DOB:** _____ / _____ / _____

AUTHORIZATION TO PROVIDE CARE/INSURANCE PAYMENTS

I hereby give consent to DERMATOLOGY & SKIN CARE BY SHELLY to provide whatever treatment they may deem necessary to the patient above. The insured party must sign for all claims. Dependent patients must sign, if not a minor. I authorize insurance companies, organizations, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to my claim. I certify that the information I provided to be true and correct. I know it is a crime to fill out this form with facts I know to be false or omit facts that are important. I assign payment directly to providers of Dermatology & Skin Care by Shelly which may be due from Medicare or any other insurance company. I understand I am financially responsible to pay Dermatology & Skin Care by Shelly for any non-covered insurance services.

Signature: _____ **Date:** _____ **Patient Name (Please Print)** _____

GENERAL CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent to care, treatment, testing and all other services performed by healthcare providers at Dermatology & Skin Care by Shelly. I understand that I have the right to refuse to consent to any proposed care, testing, surgeries or procedures. I also understand that I have the right to ask questions and discuss my concerns with my healthcare provider. I am aware that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees will be made to me as to the outcome of my care, examination, and/or treatment from Dermatology & Skin Care by Shelly. I understand that imagery and photography may be used in the course of my visits in order to protect and authenticate my medical identity. I understand that I am required to sign this consent annually or whenever the office deems it necessary. I understand that I may revoke this consent at any time by writing to Dermatology & Skin Care by Shelly at 1598 Susan A Williams Way, Suite E, Chino Valley, AZ 86323. By signing this form, I agree that I have read and fully understand the content and references contained above in this general consent form in its entirety. I acknowledge that all of my questions have been answered to my personal satisfaction.

Signature: _____

Print Name: _____ **Date:** _____

NAME: _____ **DOB:** _____ / _____ / _____

RECEIPT/REVIEW OF HIPAA PRIVACY PRACTICES

I understand that as part of my health care, Dermatology & Skin Care by Shelly originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have reviewed and understand that Dermatology & Skin Care by Shelly *Notice of Privacy Practices* provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Dermatology & Skin Care by Shelly’s Notice of Privacy Practices prior to signing this acknowledgement; I understand that Dermatology & Skin Care by Shelly reserves the right to change their Notice of Privacy Practices, and prior to any implementation of this, will mail a copy of any revised notice to the address I’ve provided, if requested.

Patient or Authorized Representative’s Signature

_____ **Date** ____ / ____ / _____

Printed Name

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

Individual refused to sign

Communication barrier prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (please specify)

Date _____ Signature of Witness

NAME: _____ DOB: _____ / _____ / _____

*****Updated as of 12/29/2025

Thank you for choosing us as your healthcare provider. We are here to provide you with excellence of care in a warm friendly environment. The following financial policy is to inform you on our systems regarding insurance billing and what is expected from you regarding payments. We would like to emphasize that as a medical care provider our relationship is with you and not with your insurance company. It is your responsibility to know your policy and provide correct information.

FINANCIAL POLICY

It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations. This information is provided by your insurance carrier. As a courtesy, we will file your insurance and obtain authorization if needed. We allow 60 days for your insurance company to make payment. Your prompt response to your insurance company's or our requests for information is expected. A prompt response would be within 7 days. If you do not respond to requests for more information the balance on the account will be due immediately. It is your responsibility to check with your insurance company to see if the doctor is contracted with them. You are responsible for providing the most up to date and correct information regarding insurance at the time of the visit. If there are changes to your insurance during the billing process it is your responsibility to inform the Financial Coordinator immediately. The Financial Coordinator will determine at that time if billing another insurance or back billing for services will be performed. If it is determined this service will not be performed the amount due will be your responsibility. Our financial coordinator is dedicated to making your experience with our Financial Department a positive one. She will go over your Health Insurance Plan with you and your estimated portion due. Your estimated portion is expected prior to any anticipated service, unless other written arrangements have been made with the financial coordinator. This will be an estimate only until insurance has paid their portion. There may be a balance owing and we request you pay that balance in 30 days unless other written arrangements have been made with the financial coordinator. In the event a refund is due, we will send you a refund check within 30 days.

LATE CANCELLATION & NO SHOW NO CALL POLICY

Patients will automatically be charged \$50 in the event of cancelling an appointment with less than 24 business hours notice. If you need to cancel over a weekend for a Monday appointment, please be aware that this is outside the 24 business hour policy and may incur a \$50 charge due to office inability to fill the appointment slot. There will be a \$75 charge associated with a No Show, No Call. Patients who no-show 2 times without payment of fees prior to appointment will be rescheduled.

INSUFFICIENT FUND/RETURNED CHECK POLICY

If your check is returned there will be a \$25.00 NSF fee charged to your account. You need to contact this office immediately when notified by your bank of non-sufficient funds. We use the Yavapai County Bad Check Program to assist in recovering funds. We understand mistakes happen, that is why we allow two weeks from the date the bank sends the check back to us before contacting the Yavapai County Bad Check Program. We will make multiple attempts to contact you during those two weeks.

PAYMENT IS DUE AT THE TIME OF SERVICE

I understand that office visit charges are payable on the day service is rendered. **As of 1/01/2026, there will be a 3% Credit Card processing fee for all cosmetic or cash pay visits. This does not apply to copays or insurance bills.** If your account becomes over 60 days old the account will be charged a finance charge of 18% annum. If your account is not paid according to the above terms, please understand that our office reports to an outside collection agency. In the event that your account is turned over for collection, you agree to pay all additional fees assessed in the collection of the debt. These fees include a 35% collection agency fees and attorney fees. Thank you for your cooperation and if you have any questions please ask. We are here to help! I understand and agree to policies outlined above:

**** ALL PAYMENTS ARE FINAL ****

PATIENT/PATIENT /REPRESENTATIVE SIGNATURE/Relationship

DATE

Shelly L Crossman FNP-C, DCNP