DERMATOLOGY
& SKIN CARE 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 AT THIS TIME:**_____

SOCIAL SECURITY # _____

EMERGENCY CONTACT:_____RELATIONSHIP:_____
PHONE:_____

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

NAME:_____RELATIONSHIP:_____

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

_____

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

FYI: WE HAVE YOU PUT THE NAME AT THE TOP OF EACH PAGE BECAUSE IF THEY BECOME SEPARATED WE WOULD NOT KNOW WHOM THEY BELONG TO.

INSURANCE 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 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 _____

FYI: IF YOU DO NOT CONSENT, PLEASE ASK THE FRONT DESK FOR A MEDICATION RECORD SHEET. IF YOUR PHARMACY DOES NOT PARTICIPATE WITH THIS FEATURE, WE WILL KINDLY ASK YOU YOU PROVIDE A MEDICATIONS LIST.

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

SUPPLEMENTS AND VITAMINS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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

- ☐ Pacemaker
- ☐ Blood Clotting Disorder
- ☐ HIV/AIDS
- ☐ Organ Transplant
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Heart Disease
- ☐ Liver Disease
- ☐ Depression
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis
- ☐ Hepatitis
- ☐ Psoriasis
- ☐ Eczema
- ☐ Kidney Disease

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

☐ **MusculoskeletalDisorders**
(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 drink / day | More than 1 drink / day |

<u>For Patients 66 and Older:</u>

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. 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)

_____

_____ _____

Signature of Witness Date

NAME:_____DOB:_____/_____/_____

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.

NO SHOW NO CALL POLICY

Patients will automatically be charged $50 in the event of cancelling an appointment with less than 24 hours notice. There will be a $75 charge associated with a No Show, No Call.

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. 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******

_____/____/20_____

PATIENT/PATIENT /REPRESENTATIVE SIGNATURE/Relationship DATE

Shelly L Crossman FNP-C, DCNP