PATIENT INFORMATION: Date:_____

NAME:_____ Mr. Mrs. Ms. Miss
Last First MI Circle one

PHONE: (Home)_____ (Cell) _____

E-MAIL ADDRESS:_____

ADDRESS:_____
Street Address City State Zip Code

BIRTHDATE:_____/_____/_____ AGE: _____ SSN:_____ SEX: M_____F_____

OCCUPATION:_____EMPLOYER:_____

MARITAL STATUS:_____ SPOUSE'S NAME: _____

PATIENT'S PERSONAL PHYSICIAN:_____

EMERGENCY CONTACT:_____
Name Phone # Relationship

BILLING INFORMATION: (Write ***"SAME"*** if patient, otherwise please provide information) *If **STUDENT** please put parents/guardian information here.*

RESPONSIBLE PARTY: _____
Last First MI

ADDRESS:_____
Street Address City State Zip Code

PATIENT REFERRAL SOURCE: How did you hear about our practice? (Please check all that apply)

- ○ ANOTHER PHYSICIAN/PROVIDER:_____
- ○ INSURANCE COMPANY:_____
- ○ FRIEND/FAMILY MEMBER:_____
- ○ INTERNET/WEB SEARCH
- ○ OTHER – PLEASE LIST:_____

PRIVACY POLICY NOTICE

I acknowledge that I understand the privacy policies mandated by the Health Insurance Portability and Accountability Act (HIPAA) that went into effect April 14, 2003.

FINANCIAL AGREEMENT & INSURANCE AUTHORIZATION

I request that payment of authorized Medicare / Medigap or other insurance benefits be made on my behalf to the Fort Collins Skin Clinic, P.C. for any services furnished to me by either physician / supplier. I authorize the Fort Collins Skin Clinic, P.C. to release to the Health Care Financing Administration and its agents or my insurance company any information needed to determine these benefits payable for related services. **I understand that I am responsible for understanding my insurance coverage. I understand that prior authorization of services does not necessarily guarantee payment. I understand that I am responsible for any deductibles, coinsurance, co-pays and services deemed not medically necessary by my insurance carrier.**

BY SIGNING BELOW, PATIENT/GUARDIAN UNDERSTANDS THE TERMS OF OUR PRIVACY POLICY NOTICE AND FINANCIAL AGREEMENT AND INSURANCE AUTHORIZATION.

SIGNED:_____ DATE: _____

PARENT/GUARDIAN SIGNATURE IF PATIENT IS A MINOR: _____

Permission to Release Medical Information

The Fort Collins Skin Clinic has my permission to leave personal medical information and billing information in the following locations in the event that I cannot be reached directly:

INITIAL BELOW:

YES _____ NO _____ N/A_____ ---- Home answering machine/voicemail

INITIAL BELOW:

YES _____ NO _____ N/A_____ ---- Cell phone voicemail

INITIAL BELOW:

YES _____ NO _____ N/A_____ ---- OK to discuss billing info/ medical results with:

Name:_____

Relationship to patient:_____

Phone number:_____

_____ _____

Print patient name Date of birth

_____ _____

Patient signature Today's date

_____ _____

Parent/Guardian signature if patient is a minor Relationship to patient

_____ _____

Office staff witness Today's date