



Patient Information

Patient Name*: _____
Date of Birth*: _____
Sex*: _____
Mailing Address*: _____
City, State, Zip*: _____
Home Phone*: _____
Cell Phone: _____
Marital Status: _____
Social Security Number*: _____
Race*: _____
Preferred Language*: _____
Email Address: _____

I authorize Vanguard Dermatology and Skin Cancer Specialists, Professional LLC to contact me in the following ways (check all that apply)*:

- | | |
|--|---|
| <input type="checkbox"/> Call me at home | <input type="checkbox"/> Leave a message on machine at home |
| <input type="checkbox"/> Call me on cell | <input type="checkbox"/> Leave a message with a family member |
| <input type="checkbox"/> Call me at work | <input type="checkbox"/> Leave a message on my cell phone |
| | <input type="checkbox"/> Leave a message at work |

I authorize Vanguard Dermatology and Skin Cancer Specialists, Professional LLC to release my protected health information (including pathology reports) to my family members*:

- No.
 Yes. _____
(Name of family member[s] to whom information may be released)

I authorize Vanguard Dermatology and Skin Cancer Specialists, Professional LLC to leave phone messages containing pathology reports*:

- No.
 Yes, on: (circle all that apply) Home Phone Cell Phone Work Phone

Emergency Contact Information

Emergency Contact Name*: _____
Phone Number*: _____
Relationship to Patient: _____

Pharmacy Information

Pharmacy Name _____
Location/Phone Number _____

*Indicates items are required in order for us to comply with new national healthcare regulations



Insurance Information

Insurance Name:

Subscriber ID:

Subscriber Name:

Subscriber Date of Birth:

Relationship to Patient:

Group Number (if any):

Primary Ins.

Secondary Ins. (if any)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Employer Information

Name of Employer (if any):

Phone Number:

Please list any doctors you would like us to coordinate with on the delivery of your medical care.

Primary Care Doctor:

Doctor's Name:

Doctor's Phone:

Referring Doctor (if different from above):

Doctor's Name:

Doctor's Phone:

Doctor's Specialty:

Other Doctors:

Doctor's Name:

Doctor's Phone:

Doctor's Specialty:

By signing this authorization, I authorize Vanguard Dermatology and Skin Cancer Specialists, Professional LLC to share my protected health information (PHI) with the above physicians.

Name (printed)

Signature

Date



PATIENT CONSENT FORM AND FINANCIAL POLICY

Use and Disclosure of Protected Health Information

With my consent, Vanguard Dermatology and Skin Cancer Specialists, Professional LLC (also referred to as “the Practice” within this form) may use and disclose protected health information (PHI) or individually identifiable health information (IIHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the Practice’s Notice of Privacy Practices for a more complete description of such users and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Vanguard Dermatology and Skin Cancer Specialists, Professional LLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Vanguard Skin Cancer Specialists, 3245 International Circle, Suite 200, Colorado Springs, CO 80910.

With my consent, Vanguard Dermatology and Skin Cancer Specialists, Professional LLC may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Vanguard Dermatology and Skin Cancer Specialists, Professional LLC may mail and/or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Vanguard Dermatology and Skin Cancer Specialists, Professional LLC restrict how it uses or discloses my PHI/IIHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Vanguard Dermatology and Skin Cancer Specialists, Professional LLC’s use and disclosure of my PHI/IIHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Vanguard Dermatology and Skin Cancer Specialists, Professional LLC may decline to provide treatment to me.

Consent for Treatment

By signing this form, you are giving your permission for the doctors and staff of *Vanguard Dermatology and Skin Cancer Specialists, Professional LLC* to treat you, including biopsy or procedure(s), as deemed necessary in the exercise of their professional judgment. Medical care requires your cooperation, so it is important that you follow the doctor’s orders, prescriptions, make and keep appointments for follow up care (as indicated), and call the office to note any changes or concerns in my condition.

Photographs

Your physician and the Practice may take photographs to record your surgery/procedure(s). Reproduction or publication of said photographs and recordings will be used for the purpose of medical/scientific study and research, education, before and after surgical portfolios, and/or documentation for your medical record.

Payment for service

The patient is responsible for paying the full amount for all services on the day of service, unless the Practice has an agreement with your insurance carrier. For insured patients, your share of the service, e.g., co-payments and unmet deductibles, will be collected upon check-in. We accept cash, check, Visa, and MasterCard.

Please initial _____



Insurance claims

For insured patients, the Practice may release any information, including the diagnosis and the records of any treatment or examination rendered to you during the period of such medical care to third party payers, including Medicare. Your insurance company, in lieu of reimbursing you directly, will pay to the doctor or medical group any benefits for services rendered. Your medical insurance carrier may pay less than the actual bill for services, so you may be responsible for payment of all services rendered. As a courtesy, the Practice will file insurance claims with standard carriers. You are responsible for making available complete insurance information for accurate filing of claims. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. It is to your advantage, as well as your responsibility, to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts. Please call your insurance company to verify your benefits. As a courtesy, our staff verifies benefits for surgery, but there can be misquotes and or misunderstandings—insurance companies do not guarantee payment when we call for authorization. You will be responsible for all fees not paid by your insurance company.

Laboratory Fees

The practice utilizes an outside laboratory for biopsies, wound cultures, and other incidental tests. For insured patients, we will provide the laboratory with your insurance information. The laboratory bills separately from the Practice, so you may expect to receive a bill from them for their services.

Referrals and Authorization

As a specialist, some insurance companies (particularly HMOs and Tricare) require that prior to any visit you must obtain an authorization or referral from your primary care physician. It is your responsibility to know if this is required for your insurance, and if so, to procure the referral. If this is not done by the day of your appointment, you will be asked to either reschedule your appointment after contacting your primary care physician, or pay for the services at the time you are seen. If your insurance company rejects a claim because a valid authorization or referral was not in place, the full cost of the visit will be your responsibility.

Financial Assistance

For patients with financial need, we offer a financial assistance program for the treatment of skin cancers. Please ask a member of our staff for more information if you are interested.

ADDITIONAL CHARGES FOR WHICH YOU MAY RESPONSIBLE

Scheduling fees

If you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. We reserve the right to charge for any appointment which is not cancelled with proper notice. No shows will automatically be charged a \$25.00 fee.

Unpaid account balances

All patient balances over 30 days old will be charged \$5.00 per month. All accounts unpaid past 90 days will accrue an additional \$25.00 transfer fee and transferred to our outside collections agency.

Patient agreement: I have read the above form and agree to the terms stated. I realize that payment is my obligation regardless of insurance or third party involvement.

Name (printed)

Signature

Date



Welcome to Vanguard Dermatology and Skin Cancer Specialists! We are committed to providing you with the highest quality patient care and experience. Please let any staff member know if we can do anything to make your visit more pleasant.

Thank you for entrusting us with your medical care.

(1) How did you hear about Vanguard Dermatology and Skin Cancer Specialists? (check all that apply)

Media/Advertising

- Flyer or Sign. Location _____
- Internet
- Magazine
- Newspaper
- Postcard or letter in the mail
- Radio (select station)
 - KVOR: 740AM
 - KRDO: 105.5FM / 1240AM
- Television
- Yellow pages

Word of mouth

- Referral from another doctor. Doctor's name _____
- Referral from another patient. Patient's name _____
- Other word of mouth. Please describe _____

Other sources

- Drove by the office and saw the sign
- Listed as part of insurance company network
- Other. Please describe _____

(2) What is the reason for your appointment today?

- Mohs Micrographic Surgery
- Other skin cancer surgery (examples: excision, cryosurgery)
- Diagnosis of potential skin cancer (examples: biopsy, skin exam)
- Cosmetic service (examples: Botox, Restylane, dermabrasion, reconstruction)
- Other dermatology concern (examples: acne, alopecia, warts, rashes)