



DERMATOLOGY • DERMATOPATHOLOGY • MOHS SURGERY • PLASTIC SURGERY • AESTHETICS

**Patient Information:**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, and Zip Code: \_\_\_\_\_

Marital Status (optional): \_\_\_\_\_ Race(optional): \_\_\_\_\_

Ethnicity (optional): \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary: \_\_\_\_\_

**I authorize Vanguard Medical Specialists, LLC to contact me as follows (check all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Call and leave message on cell | <input type="checkbox"/> Text cell                          |
| <input type="checkbox"/> Call and leave message on home | <input type="checkbox"/> Call and leave message with family |
| <input type="checkbox"/> Call and leave message on work | <input type="checkbox"/> I do not authorize any messages    |

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_

Email Address: \_\_\_\_\_ Work#: \_\_\_\_\_

What is your preferred contact: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Email: \_\_\_\_\_

By providing an e-mail address you consent to receive e-mails from Vanguard Skin Specialists

**I authorize Vanguard Medical Specialists, LLC to leave phone messages containing medical information (including pathology reports):**

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

**I authorize Vanguard Medical Specialists, 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)

**Emergency Contact Name:** \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Pharmacy Information:**

Pharmacy Name/Location: \_\_\_\_\_

**By signing this authorization, I verify the accuracy of my demographic information. I also authorize Vanguard Medical Specialists, LLC to share my protected health information (PHI) with the physicians I have listed on this form.**

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## PATIENT CONSENT FORM AND FINANCIAL POLICY

### Use and Disclosure of Protected Health Information

Vanguard Medical Specialists, LLC (also referred to as “Vanguard”) 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). I consent to Vanguard’s use and disclosure of my PHI/IIHI to carry out TPO.

Please refer to the Practice’s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to obtain a copy of my medical records by sending the practice a written request. I may also access my records through the online patient portal if I choose to use it.

I have reviewed the Notice of Privacy Practices prior to signing this consent. Vanguard reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained upon written request to Vanguard Medical Specialists, 9348 Grand Cordera Pkwy, Ste 160, Colorado Springs, CO 80924.

With my consent, Vanguard may call or text my home or other designated location, including my emergency contact if I cannot be reached, 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 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 statements. Email that contains PHI is unencrypted. Vanguard will email me a skin tips newsletter, to which I may unsubscribe with one click at any time.

I have the right to request that Vanguard 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 until other written notice is given.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. Vanguard reserves the right to decline treatment for patients who do not sign this consent form.

### Consent for Treatment

By signing this form, you are giving your permission for the doctors and medical providers of *Vanguard Medical Specialists, LLC* to treat you, including biopsy or procedure(s), as deemed necessary in the exercise of their professional judgment. This may include obtaining medical records from other doctors’ offices and medication history from external sources, e.g., Surescripts, pharmacies, etc. 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 in or concerns about your condition.

### Photographs

Your physician and Vanguard 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 deposits toward unmet deductibles, will be collected upon check-in. The Practice does not balance bill. The Surprise/Balance Billing Disclosure Form is available at all front desks and at [www.vanguardskin.com](http://www.vanguardskin.com). Wound check and suture removal visits are billed visits, depending on the type of surgery and your insurance. **If you are in a grace period with your insurance carrier, we will collect payment on the day of your appointment for all services provided.** We accept cash, check, Visa, MasterCard, Discover, and American Express.

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Please initial \_\_\_\_\_



**Insurance claims**

For insured patients, Vanguard may release any information, including the diagnosis and the records of treatment or examination rendered to you during the period of such medical care to insurance payers, including Medicare. Your insurance company, in lieu of reimbursing you directly, will pay to Vanguard any benefits for services rendered. Your insurance may pay less than the actual fees, so you may be responsible for payment of all services rendered. You are responsible for providing complete insurance information on the date of service so that Vanguard can submit accurate claims. Reduction or rejection of your claim by your insurance does not relieve your financial obligation. It is to your advantage, as well as your responsibility, to know and understand your insurance coverage. Not all services may be a covered benefit. **Dermatology is not considered preventative by most insurance carriers.** As a courtesy, Vanguard verifies benefits for surgery, but there can be misquotes or misunderstanding—insurance companies do not guarantee payment when we call for authorization. You will be responsible for all fees not paid by your insurance company.

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

**ADDITIONAL CHARGES FOR WHICH YOU MAY RESPONSIBLE**

**Laboratory Fees**

You may receive a separate bill for lab services. If your insurance requires an outside lab, Vanguard will use an outside laboratory, for biopsies, wound cultures, and other incidental tests, and we will provide the lab with your insurance information. Pathology services typically range from \$110 to \$250 per specimen. The cost can be substantially higher if additional tests or a second opinion is required. Unusually complex case may require a special stain and/or second opinion which will significantly increase cost per specimen. If you have questions about outside lab statements, please contact the lab directly.

**Scheduling fees**

If you are unable to keep your scheduled appointment, please contact our office at least 48 hours in advance. We reserve the right to charge \$50.00 for any appointment which is not cancelled with proper notice. Surgery and patch appointments that are not cancelled with proper notice will be charged \$250.00. Additionally, ***we will not continue to see patients who have no showed, cancelled or rescheduled within 48 hours of their appointment 2 times.***

**Unpaid account balances**

We send patient statements monthly. All accounts unpaid after three statements may accrue an additional \$25.00 late fee and be transferred to our outside collections agency to manage the collections process. These patients may be required to pay any patient responsibility at time of service for all future visits. Any returned checks or cancelled credit card charges will incur a fee of \$25.00

**Patient agreement:** *I have read the above form and agree to the terms stated. I hereby acknowledge receipt of Vanguard Medical Specialists, LLC's Notice of Privacy Practices. I realize that payment is my obligation regardless of insurance or third-party involvement. **Signing of the consent is acceptance of all terms as they are written. No amendments or modifications will be granted.***

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Name (printed)

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Signature

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Date



### **Consent to Obtain Medication History**

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your “medication history.” A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

**I give permission for you to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Dated:** \_\_\_\_\_

**Parent/Guardian Name (if patient is a minor):** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Dated:** \_\_\_\_\_



### 48 Hour Appointment Cancellation Policy

If you are unable to keep your scheduled appointment, please contact our office at least 48 hours in advance. If you do miss, cancel, or reschedule an appointment with less than 48 hours' notice, our cancellation policy is as follows:

#### Medically Necessary Appointments:

- **1<sup>st</sup> Instance:** If it is your first appointment with us, we will not reschedule you for 1 year. If it is not your first appointment with us, we will charge a \$50 fee if your insurance allows it.
- **2<sup>nd</sup> Instance:** If it is your first appointment with us, we will not reschedule you for 3 years. If it is not your first appointment with us, the second instance will result in dismissal from our practice. You will have to wait 3 years to reschedule.

#### Aesthetic/Cosmetic Appointments (including VISIA/Skin Care Consultations):

- **1<sup>st</sup> Instance:** We will not reschedule you within 6 months of the missed, cancelled or rescheduled appointment within 48 hours of your scheduled appointment time and we will collect a \$100 deposit for the next appointment scheduled
- **2<sup>nd</sup> Instance:** The second instance will result in dismissal from our practice. You will have to wait 3 years to reschedule.

Due to the high cost of allergens, patch appointments that are not cancelled with proper notice will always be charged \$250. Surgery and aesthetic appointments are also charged a fee of \$250.

Severe weather is excluded from the cancellation policy.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Vanguard Skin Specialists as described above.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Welcome to Vanguard Skin 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 Skin Cancer Specialists? (Check all that apply)

**Media/Advertising**

- Social Media: FB, Instagram, YouTube
- Healthgrades, Vitals, Real Self
- Internet Search
- Flyer or Sign. Location \_\_\_\_\_
- Newspaper or Magazine
- Postcard or letter in the mail
- Radio
- Television

**Word of mouth**

- Referral from another doctor
- 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 \_\_\_\_\_