Foothills

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Tucson, AZ 85741
(520) 731-1110 Fax (520) 731-6582

Today's date:	❑ Mrs. ❑ Ms. ❑ Mr. ❑ Miss

PATIENT INFORMATION

Patient's Last Name:	First Name:	Middle Initial:	Marital Status Single / Married / Divorced / Separated / Widow

Is this your legal name? ❑Yes ❑No	If not, what is your legal name?	E-mail: (provides access to patient portal)	Date of Birth: / /	Age:	Gender: ❑M ❑F

Address:	City:	State:	ZIP :

Home phone:	Cell Phone:	Work Phone:	Social Security Number:

Name of Responsible Party (if not patient):	Address (if different):	Contact Number:	Date of Birth: / /

Any restrictions contacting you?	Is it okay to call you at: ❑ Home ❑ Cell ❑ Work	Can we leave a detailed message on your phone: ❑ Home ❑Cell ❑ Work

Employer:	Occupation:	Preferred Language:

To whom may your medical information be released:	Race:	Ethnicity:

How did you hear about our practice?	Referring Physician Name & Phone:	Primary Care Physician Name & Phone:

Other family members seen here:

IN CASE OF AN EMERGENCY

Name of local friend or relative:	Relationship to patient:
Home phone:	Cell Phone:

The above information is true to the best of my knowledge. I also acknowledge that I have received and understand the HIPAA (Health Insurance Portability and Accountability Act) notice of privacy practices for protected health information from Foothills Dermatology and Facial Plastic Surgery. The release of medical information and assignment of benefits is considered in force from the date of signing until revoked in writing. By providing your email, we will grant access to our patient portal.

Patient/Guardian signature	*Date*

Insurance Information

Dr. Olson and Dr. Orlick are contracted with several insurance carriers which require appropriate referrals. Obtaining this referral is your responsibility as the patient. If you are seen without necessary authorization and/or referral, you may be liable for any charges incurred.

Primary Insurance Company:

_____

ID #_____

Group #_____

Policy Holder's Name _____

Policy Holder's SS#_____

Policy Holder's Date of Birth_____

Policy Holder's employer_____

Relationship to Patient _____

Effective Date _____

Secondary Insurance Company:

_____

ID #_____

Group #_____

Policy Holder's Name _____

Policy Holder's SS#_____

Policy Holder's Date of Birth_____

Policy Holder's employer_____

Relationship to Patient _____

Effective Date _____

Assignment of Insurance/Medicare Benefits

I hereby give consent for medical or surgical treatment to the physician to care for myself or I am duly authorized by the patient as his/her guarantor to give consent for such treatment. I understand that co-pays are payable **on the day service is rendered** and any coinsurance/deductibles or other outstanding balance will be billed to me. Failure to pay my co-pay at my appointment, will result in having to reschedule. I authorize Foothills Dermatology and Facial Plastic Surgery to bill my insurance company. I hereby authorize payment directly to the physician of any medical / surgical benefits payable to me under the conditions of my policy for services rendered. I hereby give consent to release to authorized persons, financial and medical information concerning care, treatment and charges as may be required to complete all claims for benefits.

Financial Policy

We are committed to providing you with the highest quality of patient care. A clear understanding of our financial policy is important to our professional relationship. Should you have any questions regarding this financial policy, please don't hesitate to ask for any clarification you may need.

- All patients must complete the Patient Information Forms prior to being seen.
- I understand that my co-pay, coinsurance and deductibles are a contract between me and my insurance company.
- Full payment of co-pays and/or cosmetic services is due at the time of service.
- Coinsurance and deductibles are billed to you and payment is expected on the first bill sent.
- We accept cash, checks and credit cards.
- Any returned check will incur a $25 fee.
- Financing is available through Care Credit. (Apply at www.carecredit.com or fill out an application in our office) Financing options may vary.
- We do have a 24 hour cancellation policy. Failure to cancel your appointment more than 24 hours prior to your appointment time will incur a $25 cancelation fee or a $25 no-show fee if you fail to show up at all.
- Your services may incur additional charges billed by outside vendors including but not limited to pathology services or facility charges.
- I will fully discuss any procedure risks, benefits and alternative treatments with my provider. Risks may include poor cosmetic result, recurrence, bleeding, infection and numbness.

I understand that my contract is between Foothills Dermatology and Facial Plastic Surgery and myself. I agree to pay any balance within two billing cycles. In the event of default of payment, I shall be responsible for all costs of collections, including any legal fees incurred as a result of the collection action. My signature below signifies my understanding of the above policies:

_____ _____

Patient (or Responsible Party) Signature Date

Foothills

PATIENT HEALTH HISTORY

Patient Name:_____ Date of Birth:_____

Height:_____ Weight: _____

Check all current or past medical conditions:

- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ Diabetes
- ❑ TIA
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Bleeding Disorder
- ❑ Problem Scarring
- ❑ Stroke
- ❑ Seizure Disorder
- ❑ High Blood Pressure
- ❑ Current Pregnancy
- ❑ HIV/AIDS
- ❑ Hepatitis B or C
- ❑ Depression Disorder
- ❑ Anxiety Disorder
- ❑ Thyroid Disease
- ❑ Blood Clots
- ❑ Angina/Chest Pain
- ❑ Skin Ulcers/Keloids
- ❑ Melanoma
- ❑ Unusual Moles
- ❑ Cancer
  Type: _____
- ❑ Heart Disease
  Type: _____
- ❑ Other:_____

Do you need to take antibiotics prior to surgery or dental procedures? ❑ Yes ❑ No

List all current medications and dosages: _____

_____

List all drug allergies: _____

_____

List all past surgeries: _____

_____

Do you smoke or use tobacco: ❑ Yes ❑ No How much do you use daily? _____

Are you a past smoker or tobacco user? ❑ Yes ❑ No When did you quit? _____

Do you consume alcohol? ❑ Yes ❑ No How much do you consume daily? _____

Are you a past alcohol user? ❑ Yes ❑ No When did you quit? _____

Have any close relatives had any of the following?

❑ Melanoma ❑ Head or neck cancer ❑ Skin cancer other than melanoma ❑ Unusual mole

What is the nature of your visit?_____

I have read this questionnaire and answered the questions to the best of my knowledge. I am responsible to notify the office and the physician if any changes occur in my medical condition. If I fail to keep the doctor informed on my full medical history, I may be at an increased risk for complications or unexpected results from the planned treatments.

Patient Signature:_____ Date:_____

(Signature of a parent or legal guardian is required for patients under the age of 18 years.)

PRIVACY POLICY

It is the policy of Foothills Dermatology and Facial Plastic Surgery that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will –

- **Adhere to the standards set forth in the Notice of Privacy Practices**
- **Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for any uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.**
- **Use and disclose PHI to remind patients of their appointments unless they instruct us not to.**
- **Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will:**
  - **Implement reasonable measures to protect the integrity of all PHI maintained about patients.**
- **Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patients' individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.**
- **Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:**
  - **Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.**
  - **Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.**
- **Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if she/he believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will :**
  - **Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.**
  - **Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.**
- **All physicians and staff at our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their requests are in writing.**
- **All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.**
- **All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary actions, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personal rules and regulations.**
- **Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.**

- **PLEASE SIGN**_____ **DATE** _____

*These Guidelines for Policy Adherence may not be explicitly stated in the Privacy Rule. Some are based on our interpretation of the "minimum necessary" standard and our experience in practice management. If stated in the Privacy Rule, it is so indicated by the notation (Regulation) at the end of the Guidelines.

EMAIL CONSENT

Dear Valued Patient,

Foothills Dermatology and Facial Plastic Surgery is pleased to announce to you that we are offering a newsletter and specials via email. These publications include exciting new information as well as promotional specials. If you would like to receive these newsletters, please indicate your e-mail address on the line below. Providing your e-mail address allows permission to email you the newsletter/specials regarding Foothills Dermatology and Facial Plastic Surgery.

If you are the parent or legal guardian and would like to receive our e-mail specials, please include **your** name and e-mail below.

Name: _____

Please include your birth month and day to receive our specials: _____

E-mail address: _____

Signature: _____ Date: _____