Colorado Springs Dermatology Clinic, P.C.

Last Name: _____First Name: _____MI:_____

How would you like to be addressed?_____

Address: _____

City:_____ State: _____ Zip Code:_____

SS#_____-_____-_____ Date of Birth:_____/_____/_____ Gender: M /F /OTHER

Home Phone: _____ Cell Phone:_____

May we leave a message at this number? ☐Y ☐N May we leave a message at this number? ☐Y ☐N

Mailing Address: (If Different) _____

Primary Care Physician: _____ Phone:_____

Referred By: _____

If referred by a physician, please include phone number:_____

Patient's Employer: _____ Work Phone: _____

May we leave a message at this number? □Y □N

Name of Insurance Company: _____

Policy Holder's Name:_____ Date of Birth _____/_____/_____

Policy Holder's SS#:_____-_____-_____ Policy Number: _____

Group Name/Number: _____

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Financial & Information Release:

Use and disclosure of protected health information: With my consent, Colorado Springs Dermatology Clinic (the practice) 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 uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Prescription Drug Monitoring Database: You may be given a prescription for a "controlled" (Schedule II through V) drug. Your identifying prescription information will be entered into Colorado's electronic Prescription Drug Monitoring Database (PDMD) when this drug is dispensed to you. Your prescription information in the database is protected health record and cannot be accessed by non-caregivers except as part of an authorized investigation. You have the right to access your information in the PDMP through the Colorado Board of Pharmacy. You may seek corrections to the information as you would your other medical records.

Medicare Consent: I certify that the information given by me in applying for payment under Title SVII and/or Title XIX of the Social Security Administration or its intermediary carriers any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services. I understand that I am responsible for my health insurance deductibles and coinsurance and any co-payment amounts.

Payment for Service: Payment is expected at the time of service; insurance co-payments are mandated by your insurance company and must be made today. I understand and agree that if my insurance carrier denies benefits for any reason including, "not covered" or "cosmetic" I am responsible for the full amount for services provided. I request that payment be made payable to Colorado Springs Dermatology Clinic. In the event my account is turned over to a collection agency, I agree to pay all costs of collection. I understand and agree to pay a returned check charge of $40.00 per returned check.

Signature of PATIENT or GUARDIAN: _____Date: _____

Colorado Springs Dermatology Clinic, PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.