MONTROSE DERMATOLOGY + Cosmetics

2730 Commercial Way, Montrose CO 81401
Phone: 970-964-4036 Fax: 970-964-4038
www.MontroseDermatology.com

PATIENT REGISTRATION FORM

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Living Together ☐ **Sex:** M ☐ F ☐

Date of Birth: _____ **SSN:** _____

Preferred Language (please circle):	English Spanish Other Declined
Ethnic Group (please circle):	Unknown Hispanic/Latino Not Hispanic/Latino Declined
Race (please circle):	White African American/Black Asian American Indian Declined Other:_____

Email Address:_____

Mailing Address: _____
City, State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Best Number to leave an Appointment Reminder call: ____ Home ____Cell *OK to leave a detailed message? Y N

Employed by:_____
Work Phone #:_____

Emergency Contact Name:_____ **Phone**: _____

How did you learn about our practice? _____

Others we may share your health information with (such as biopsy results, etc):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Parent/Guardian name for Minor (under the age of 18)

First:_____ Last:_____

SSN:_____ Date of birth:_____

Billing Address:_____

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INSURANCE INFORMATION

***PLEASE bring your insurance cards & a photo ID with you to your appointment**

☐ **Insurance** OR ☐ **Self Pay**

Primary Policy

Name of Insurance:_____

Policy or Member #:_____ Group #:_____

Insurance Address & Phone #:_____

Secondary Policy

Name of Insurance:_____

Policy or Member #:_____ Group #:_____

Insurance Address & Phone #:_____

Additional Insurance

Name of Insurance: _____

Policy or Member #:_____ Group #:_____

Insurance Address & Phone #:_____

If you are not the policy holder of an insurance listed above, please fill in the information below.

Name of Insurance: _____

Name of Policy Holder: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's SSN: _____

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POLICIES AND INFORMATION

Basic Policies:

- Please be on time for your appointments.
- If you are late for your scheduled appointment, there is a chance that you will be rescheduled.
- We require at least 24 hours notice to cancel appointments. If you miss two consecutive appointments you will be required to prepay your next appointment in order to reschedule. If you miss a third appointment you will be discharged from the practice. These rules are subject to change at the provider's discretion. Failure to show for appointments without prior notification *may* result in fees.
- Patients under the age of 18 require a parent or guardian that can legally give consent for treatment for the minor patient to be present at all appointments.
- Payment for services is due in full at the time the service is provided in our office.

Financial Policies:

Insurance Coverage
We will bill most insurance carriers if proper identification is provided to us. Insurance cards must be present along with a valid picture ID in order for us to bill your insurance for you. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. Copayments are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for your care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

Communicating changes to your insurance is your responsibility
If you fail to communicate changes in insurance, you may be responsible for paying your medical bill out of pocket.

Surgery Fees
All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier and this is your responsibility to obtain this prior to your procedure.

Non-covered Services
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

NSF Checks (Checks that are returned by the bank unpaid)
There will be a fee of $35.00 added to the account balance in the event that a check is returned unpaid.

Refunds
Deposits made for cosmetic services are not eligible for refunds except in extenuating circumstances. Please be advised your request for a refund may be denied.

Personal Injury Cases
This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment in full at the time of service. We do not accept liens.

Balances Sent to Collections
In the event your account has a balance after all attempts have been made to collect said balance, your account will be forwarded to an outside collection agency. If your account is sent to collection, you are responsible for all amounts due plus costs of collection including:

- Handling charge up to fifty percent (50%) of your account balance if it must be sent to collection.
- All collection expenses charged by the collection agency.
- Court costs and attorneys' fees.

Patients that have been sent to collections will be discharged from the clinic.

Release of Information
I authorize Montrose Dermatology to release to my insurance carrier(s) and/or CMS and its agents and/or my secondary insurer any information needed to determine benefits or benefits payable for related services.

I hereby authorize health providers at Montrose Dermatology to release any information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.

I hereby authorize and direct my insurer to issue payment check(s) for benefits due me for the services rendered by any providers affiliated with Montrose Dermatology. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

☐ **YES! Please add me to your eNewsletter subscription.**

I have read and agree to the Financial Policy and Release of Information paragraphs stated above that apply to me.

_____ _____
Patient or Responsible Party signature Date

_____ _____
Printed Name of Patient or Responsible Party DOB of Patient

_____ _____
Relationship to Patient Phone

Pathology Billing: ****Please Note:** In the event that a pathology specimen is sent out for processing, you will receive bills for these services from an outside agency. The majority of these are sent to University of Utah Health Care (800-245-0357) or Mountain West Dermatology (970-245-5280). It is your responsibility to understand any coverage limitations associated with your particular insurance policy including but not limited to coverage in another state, high deductibles and other limitations. Please contact your insurance company to inquire about such limitations you may have for pathology specimen preparation or interpretation at either of these facilities prior to your appointment if possible. **Your signature below indicates acknowledgment of our Pathology Billing policy.**

_____ _____
Patient or Responsible Party signature Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of Montrose Dermatology. I hereby acknowledge receipt of Montrose Dermatology's Notice of Privacy Practices.

Signature:_____

Print Name: _____

Date: _____

OR

I am a parent or legal guardian of _____[patient name].
I hereby acknowledge receipt of Montrose Dermatology's Notice of Privacy Practices with respect to the patient.

Signature:_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Print Name: _____

Date: _____

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Name:_____
Date of Birth:_____

History and Intake Form

PAST MEDICAL HISTORY OR **NONE: (please circle all that apply)**

Autoimmune disease
Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lupus
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Other:_____

PAST SURGICAL HISTORY OR **NONE**: **(please circle all that apply)**

Appendix Removed
Bladder Removed
Cataract surgery
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colon removal
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovary removal
Prostate Removed: Prostate Cancer
Tonsillectomy
Tubal ligation
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy

Other:_____

SKIN DISEASE HISTORY OR **NONE**: **(please circle all that apply)**

Acne
Actinic Keratoses
Eczema
Hay Fever/Allergies
Psoriasis
Vitiligo

Other:_____

Name:_____
Date of Birth:_____

MISCELLANEOUS: (please circle)
Have you *ever* used a tanning bed? **YES** OR **NO**

Do you have a family history of Melanoma? **YES** OR **NO**
If yes, which relative(s)?_____

SKIN CANCER HISTORY OR **NONE:**

Basal Cell Carcinoma: list locations and dates

_____
_____
_____

Squamous Cell Carcinoma: list locations and dates

_____
_____
_____

Melanoma: list locations, dates and thickness (if known)

_____
_____
_____

MEDICATIONS OR **NONE**: **(please list all current medications)**

_____
_____
_____
_____

MEDICATION ALLERGIES OR **NO KNOWN DRUG ALLERGIES: (please list all known allergies)**

_____
_____
_____

SOCIAL HISTORY: **(please circle all that apply)**

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Recreational drug use? NO YES

Name:_____
Date of Birth:_____

NAME OF PRIMARY PHYSICIAN:_____

Address (if known): _____

City, State: _____ Zip Code:_____

Office Phone#: _____

PREFERRED PHARMACY NAME: _____

City or Zip Code:_____

REASON FOR YOUR APPOINTMENT WITH MONTROSE DERMATOLOGY:

_____