Idaho Dermatology Mohs Collective PLLC
Heather Layher, DO, MBA, FAAD   Ashley Cafferty, PA-c
3668 N. Harbor Ln. Boise, ID 83703
P: (208) 600-1330 F: (208) 567-3523
www.dermmohscollective.com

Patient Intake Form

Name: ____
(Last) (First) (Middle Initial)

Birthdate: ____________________ Email: ____

Phone: _____________________ Preferred Language: ________________________________

Preferred Pharmacy (Name & Location): ____

Primary Care/Referring Provider Name/Clinic: _______________________________________

Medications (Please list all current medications):

____

____

____

Allergies (Please list all allergies):

____

____

____

Skin Disease History (Check all that apply):

☐ Acne	☐ Dry Skin	☐ Rash
☐ Actinic Keratoses	☐ Eczema	☐ Precancerous Moles
☐ Asthma	☐ Flaking or itching scalp	☐ Squamous Cell Skin Cancer
☐ Basal Cell Skin Cancer	☐ Hay Fever/Allergies	☐ Skin Cancer
☐ Blistering Sunburns	☐ Poison Ivy	☐ Melanoma

Current Problems with (Check all that apply):

☐ Bleeding	☐ Fever or Chills	☐ Bloody Stool/Urine	☐ Shortness of breath
☐ Healing	☐ Night Sweats	☐ Joint Aches	☐ Wheezing
☐ Scarring	☐ Muscle Weakness	☐ Anxiety/Depression	☐ Rash
☐ Thyroid Problems	☐ Neck Stiffness	☐ Immunosuppression	☐ Sore Throat
☐ Headaches	☐ Hay Fever	☐ Blurry Vision	☐ Seizures
☐ Chest Pain	☐ Abdominal Pain	☐ Cough	☐ Unintentional Weight Loss

Past Medical History (Check all that Apply):

☐ None	☐ Disease Caused by COVID-19	☐ Hypothyroidism
☐ Anxiety	☐ Elevated Blood Pressure	☐ Leukemia
☐ Arthritis	☐ End Stage Renal Disease	☐ Lung Cancer
☐ Asthma	☐ Epilepsy	☐ Lymphoma
☐ Atrial Fibrillation	☐ GERD	☐ Pacemaker
☐ BPH	☐ Hypertension	☐ Prostate Cancer
☐ Stroke	☐ Hearing Loss	☐ Radiation Treatment
☐ COPD	☐ HIV Infection	☐ Seizures
☐ Coronary Arteriosclerosis	☐ High Cholesterol	☐ Valve Replacement
☐ Depressive Disorder	☐ Hyperthyroidism	☐ Diabetes
☐ Inflammatory Liver Disease		

Alerts (Check all that apply):

☐ Allergy to Latex	☐ Rapid Heartbeat with Epinephrine
☐ Allergy to Lidocaine	☐ Pacemaker
☐ Allergy to Adhesive	☐ Blood Thinners
☐ Allergy to Topical Antibiotic Ointment	☐ Premedication prior to Procedures
☐ Artificial/Damaged Heart Valve	☐ Artificial Joints within the Last 2 Years
☐ Defibrillator	☐ Pregnant or Planning a Pregnancy

Past Surgical History (Please list past surgeries and procedures):

____

____

____

History of Smoking (check one): Never smoked ☐ Former smoker ☐

Smokes Less than daily ☐ Smokes Daily ☐

Do you wear Sunscreen? Yes ☐ No ☐ What SPF? ____________________

Do you tan in a tanning salon? Yes ☐ No ☐

Do you have a family history of Melanoma? Yes ☐ No ☐

If yes, which relative(s)? ____

Any other family skin cancer history? ____

Is there anything else you'd like to share with us?

____

____

____

Patient/Guardian Name: ____

Signature: ______________________________

Date: ________________________

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Acknowledgement of HIPAA Privacy Practices

Your Rights

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or summary of your health information, usually within 30 days of your request.
- You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- You can ask us to contact you in a specific way or send mail to a different address.
- You can ask us not to share or use certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
- You can ask for a list of the times we've shared your health information for the six years prior to the date you ask, who we shared it with, and why.
- You can ask for a paper copy of this notice at any time.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.
- You have the right to share your personal healthcare information with your family, close friends, or others involved in your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share information when needed to lessen a serious or imminent threat to health or safety.
- We will never share your information for marketing purposes, sale your information, or share psychotherapy notes unless you give us written permission.

Our Uses and Disclosures

- We can use your health information and share it with other professionals who are treating you.
- We can use and share your health information to run our practice, improve your care, and contact you when it is necessary.
- We can use and share your health information to bill and get payment from health plans or other entities.
- We can share health information about you for certain situations such as:
    - Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety
- We can use or share your information for health research
- We will share information about you if state or federal law requires it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- We can share health information about you with organ procurement organizations
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- We can use or share health information about you:
    - For workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies authorized by law, for special government functions such as military, national security, and presidential protective services
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices as described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

This notice of Privacy Practices applies to Idaho Dermatology Mohs Collective. By signing this form, you acknowledge and understand the Privacy Practices, and agree to them as they have been stated.

Patient/Guardian Name: ____

Patient/Guardian Signature:______________________________ Date:____________________

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Patient Financial Responsibility Form

Thank you for choosing Idaho Dermatology Mohs Collective for your dermatological needs. We are committed to providing you with the highest quality care. We ask that you read and sign this form to acknowledge your understanding of our patient financial responsibilities.

Patient Financial Responsibilities

- The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding your insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan.
- Coinsurance, deductibles, and non-covered items are due 30 days from the receipt of billing.
- Patients will be sent to collections for failure to pay their obligation after the third statement at 90 days.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include a $30.00 charge for returned checks.
- **No Show and Cancellation Policy** – 24-hour notice is required when cancelling an appointment. This allows us time to offer the appointment to another patient in need. Please note you will be charged the following fee if you no-show or cancel with less than 24-hour notice. *Failure to show for 3 appointments will result in discharge from the clinic.*
    - $75 for a routine clinic appointment or a blue-light photodynamic therapy appointment
    - $200 for an excision or EDC appointment
    - $500 for Mohs
    - Full quoted amount for cosmetic appointments

By my signature below, I hereby authorize assignment of financial benefits directly to Idaho Dermatology Mohs Collective and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Patient/Guardian Name: ____

Patient/Guardian Signature: _______________________________________

Date: ______________________________

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Authorization to Release Healthcare Information

We will happily send your records to your Primary Care Provider or one other provider of your choice free of charge. Sending of records to additional providers will be charged $10.00 per provider or 10 cents per page for large records above 100 pages. We will also print any records created under our care for you free of charge. Printing of any records not created under our care, for example those created by providers before you transferred into our care, will be subject to a $10.00 charge or 10 cents per page for large records above 100 pages.

Patient Name: ____

Birth Date: __________________ SSN#: __________________ Phone: __________________

Release From: ________________________ Release To: Idaho Dermatology Mohs Collective

________________________ 3668 N Harbor Lane

________________________ Boise ID 83703

Phone: ________________________ Phone: 208-600-1330

Fax: ________________________ Fax: 208-567-3523

Please select one of the following options:

☐ Patient will pick up and hand carry records.

☐ Idaho Dermatology Mohs Collective will mail records to the individual/organization above.

☐ Idaho Dermatology Mohs Collective will fax records to the individual/organization above.

☐ The individual or organization above will mail or fax records to Idaho Dermatology Mohs Collective.

Information to be released:

☐ All Medical Records

☐ All Dermatological Records

☐ Pathology/Laboratory Records

☐ Other ____

Exceptions (if any, see disclosure statement below):

____

____

For the purpose of:

☐ Transfer of Medical Care ☐ Billing Purposes ☐ Legal Matters

☐ Personal ☐ Continued Care

Authorization to Release Healthcare Information

I understand that authorizing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I authorize the use and disclosure of my entire patient file including any information that I might consider sensitive such as mental health, sexually transmitted diseases, alcohol/drug abuse treatment, HIV/AIDS related treatment, etc. If there are certain parts of my medical record that I do not want disclosed, I have written those exceptions on this form in the space above. I hereby release the supplier and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized. I understand that once the above information is disclosed, the information may not be protected by federal privacy law and may potentially be disclosed by the recipient. I understand that I may revoke this authorization at any time by notifying Idaho Dermatology Mohs Collective PLLC in writing and completing the Revocation of Authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire 6 months from the date of signature.

Please allow 7-10 business days for processing.

Printed Name of Patient or Guardian: _____________________________ Date: ___________

Signature of Patient or Guardian: _________________________________ Date: ___________

For Office Use Only

Signature of Person Releasing: ___________________________________ Date: ___________

[ ] Mailed: ____________________ [ ] Faxed: ____________________

Initial/Date Initial/Date

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Emergency Contact

I authorize Idaho Dermatology Mohs Collective to contact and share my medical information with the following people:

Name: ____ Phone: _________________

Relationship to the Patient: _____________________________

Name: ____ Phone: _________________

Relationship to the Patient: _____________________________

This authorization can be rescinded at any time by contacting Idaho Dermatology Mohs Collective.

Patient/Guardian Name: _____________________________________

Patient/Guardian Signature: __________________________________

Date: _________________________

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Credit Card on File Authorization

Thank you for choosing Idaho Dermatology Mohs Collective for your dermatological needs. We ask that you read and sign this form to acknowledge your understanding of our Credit Card on File (CCOF) Policy.

Idaho Dermatology Mohs Collective offers a Credit Card on File program as a convenient method of paying for the portion of your services that are deemed your responsibility by your insurance carrier. These include copays, deductibles, and co-insurances.

Idaho Dermatology Mohs Collective utilizes ModMed Pay to process all patient payments. ModMed Pay is a secure credit card processor affiliated with Modernizing Medicine that maintains complete confidentiality of patient financial information. When authorizing your card to remain on file, your credit card information is irreversibly tokenized, or given a unique alternate token number, in the ModMed Pay system. Your specific credit card information, including card number, expiration date, security code, or billing zip code, do not remain on file. Any future charges to the credit card on file are run according to your unique token. To minimize any exposure of your card information, our ModMed Pay terminal conveniently allows your information to be privately saved by inserting, swiping or tapping the terminal. Please do not write your card information on this form.

Our clinic policy regarding Credit Card on File is as follows:

> *While our clinic does not require patients to authorize Credit Card on File, it is strongly encouraged to ensure timely payment of any patient financial obligations for services provided by our clinic. Any patient declining to allow Credit Card on File shall understand that our clinic will happily continue to provide care so long as they remain up-to-date on paying their statements. Should patients fail to pay their first statement, they will be denied further appointments until their balance is paid. Should patients fail to pay by their second statement, the patient will be discharged from the clinic in the appropriate manner set forth by the Idaho Board of Medicine. Should patient continue to fail to pay their balance by the third statement, they will be sent to collections.*

By my signature below, I hereby authorize and request that Idaho Dermatology Mohs Collective charge my credit card for the balance due that my health plan has identified as my financial responsibility. This authorization relates to all charges not covered by my insurance company for services provided to me by Idaho Dermatology Mohs Collective. This authorization will remain in effect until revoked by me in writing.

Patient/Guardian Name: ___________________________________ DOB: _____________

- ☐ Please keep my credit card on file in tokenized form and charge my account to pay for charges not paid by my insurance plan.

  Charge limits: Our company policy is to obtain verbal authorization on any charges over $100.00. Any charges less than $100.00 do not require verbal authorization and will be run automatically. By signing this authorization, you agree to these terms. If you would like to increase the amount for which verbal authorization is required, please indicate the amount here: $_________.

Patient/Guardian Signature: _________________________________ Date: _____________

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Q&A About Credit Card on File

How does this work? At patient registration or check-in, we will ask you to sign this Credit Card on File Authorization form. As part of this agreement, you will acknowledge our charge limit guidelines, as well as set an amount for which you authorize us to process without verbal authorization. Charges exceeding this amount will require verbal authorization from the card holder prior to processing payments. At check out, you will be asked to insert, swipe or tap your credit card in our ModMed Pay terminal. If you owe a balance on the day of service, you can both pay the balance and save your card information at the same time. If you do not owe a balance, you can simply save your card information without making any payment. Lastly, you can call in after your appointment and provide the credit card information over the phone to one of our highly trained staff.

What are the benefits to me? You can use your credit card on file to pay for copays, coinsurance, and deductibles at future visits. It makes checkout easier, faster, and more efficient.

What types of credit cards are allowed? We accept Visa, Mastercard, American Express, and Discover, as well as debit cards.

How can I be assured that my credit card information will remain safe? We are under the strict rules and guidelines of Payment Card Industry (PCI) Compliance, and HIPAA Compliance to protect patient privacy and credit card information is considered protected health information. ModMed Pay, our credit card processing vendor, does not store your direct credit card information, but rather stores a unique token number that enables us to run bank card transactions on our computer system. Our employees will not have access to your bank card.