Idaho Dermatology Mohs Collective PLLC
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Patient Intake Form

Name:_____ **Birthdate:**_____

Email: _____**Phone:**_____

Preferred Pharmacy (Name & Location): _____

Primary Care/Referring Provider Name & Clinic: _____

_____

Past Medical History (mark all that apply):

Blood thinners ☐	Pacemaker/ Defibrillator ☐	Artificial Joints Year:	Artificial Heart Valve ☐
High Blood Pressure ☐	Hepatitis positive ☐	Pregnant? ☐	Cancer Type: Year:
	HIV Positive ☐	Planning to Become Pregnant ☐	
Other:	Other:	Other:	Other:

Skin Disease History (mark all that apply):

Skin cancer	☐	Melanoma	☐	Blistering sunburns	☐	Abnormal moles	☐
Psoriasis	☐	Eczema	☐	Acne	☐	Other:	☐

Do you wear sunscreen? YES ☐ NO ☐ **What SPF?** _____

Any Current Problems (mark all that apply):

Bleeding	☐	Vision Changes	☐	Trouble Breathing	☐	Numbness/Tingling	☐
Loss of Balance	☐	Digestive Issues	☐	Poor Healing	☐	Keloids	☐
Weight Loss	☐	Frequent Headaches	☐	Chest Pain	☐	Autoimmune	☐

Family History (mark all that apply):

Skin cancer	☐	Melanoma	☐	Abnormal Moles	☐	Psoriasis	☐
Eczema	☐	Hay fever	☐	Asthma	☐	Other:	

Medication Allergies (mark all that apply):

Latex ☐	Lidocaine ☐	Adhesives ☐	Epinephrine ☐
Penicillin ☐	Sulfa ☐	Other:	Other:

What is your smoking status? Never smoker ☐ - Former smoker ☐ - Current every-day smoker ☐

If 65 years or older- Do you have a health care proxy in the event you are unable to make your own medical decisions? YES ☐ NO ☐

Medications:

Name	**Dose**	**Frequency**

What are your primary skin concerns?

Skin Cancer ☐	Changing Skin Lesion ☐	Moles ☐	Rash ☐
Acne ☐	Melasma ☐	Flushing ☐	Rosacea/Redness ☐
Age/brown Spots ☐	Uneven Texture ☐	Unwanted Hair ☐	Hair Loss ☐
Forehead Lines ☐ Frown Lines	Scars Keloids ☐	Skin Laxity ☐	Other:

How did you hear about us?

Google ☐	Referral ☐	Yelp ☐	Friend	Other:

Patient/Guardian Name: _____

Signature: _____ **Date:** _____

Idaho Dermatology Mohs Collective PLLC

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This authorization can be rescinded at any time by contacting Idaho Dermatology Mohs Collective.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

Idaho Dermatology Mohs Collective PLLC

Acknowledgement of HIPAA Privacy Practices

Your Rights:

- You can ask for 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 within 30 days of your request.
- You can ask us to correct health information about you if you believe it is incorrect or incomplete. We may say "no" to your request, but we will 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 have shared your health information for six years prior to the date you request it, who we shared it with, and why.
- If you have a 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 may file a complaint if you feel we have violated your rights by contacting us. You may also 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 by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you if you file 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 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 your health and safety.
- We will never share your information for marketing purposes or sale of your information unless we are given 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 to ensure we are 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 promptly inform you 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 in writing. Permission can be revoked at any time in writing.

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:** _____

Idaho Dermatology Mohs Collective PLLC

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 Policy. We offer this 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 care information is given a unique alternate token number in the ModMed Pay system. Your specific credit card information, including card number, expiration date, security code, and 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 in 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 on file 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. Any charges less than $100 does 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: $_____.

_____ I decline to authorize my credit card to be held on file and I understand if I fail to pay my balance by the second statement, I will be discharged from the clinic.

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 guideline and 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 at our ModMed Pay terminal. If you owe a balance on the day of service, you can both pay your 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 a payment. Lastly, you can call in after your appointment and provide 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 Compliance, and HIPAA Compliance to protect patient privacy. 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.

Idaho Dermatology Mohs Collective PLLC

Patient Financial Responsibility

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 the patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, you must provide the most correct and updated information about your insurance.
- Patients are responsible for payment of copays, co-insurance, deductibles, and all other procedures or treatments not covered by their insurance plan.
- Coinsurance, deductibles, and non-covered items are due 30 days from the receipts 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 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 for an appointment or cancel with less than 24 hours' notice.
    - $75 for a routine clinic appointment or a blue-light photodynamic therapy appointment
    - $200 for an excision or ED&C appointment
    - $500 for Mohs surgery
    - Full quoted amount on 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: _____