UTAH VALLEY DERMATOLOGY

-David Myers, MD - Jordan Harris, DO - Jason Evans, PA - Scott Leatham, NP-

Please complete all highlighted sections

PATIENT INFORMATION (Please Print) Date: _____

Full Legal Name: _____ Nickname: _____

Sex: M / F Marital Status: _____ SSN:_____ Date of Birth: _____

Preferred Language: _____ Race: _____ Ethnicity: Hispanic/Latino __ Non-Hispanic/Non-Latino __

Mailing Address: _____ City:_____ State:_____ Zip: _____

Preferred Phone: _____ Other Phone: _____

Email for Patient Portal **(1 patient per email)**:_____

Spouse: _____ Phone: _____

Caretaker: _____ Relationship to Patient: _____ Phone: _____

Primary Care Physician: _____

HEAD OF HOUSEHOLD (Responsible Financial Party)

Name: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____ Phone: _____

Mailing Address: _____ City:_____ State:_____ Zip: _____

Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name: _____

Name of Member: _____ Date of Birth: _____

Member ID #: _____ Relationship of patient to the Member_____

Policy Holder's Employer: _____

Address if different from patient_____

Secondary Insurance Name: _____

Name of Member: _____ Date of Birth: _____

Member ID #: _____ Relationship of patient to the Member_____

Policy Holder's Employer: _____

Address if different from patient_____

HOW DID YOU HEAR ABOUT US? (Please circle all that apply)

Friend/Family Insurance Instagram Facebook Online Reviews Google (search engine)

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Financial Responsibility (Office Policy on Payment)

By signing below, I agree to pay all amount(s) owed by me. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. I authorize insurance benefits to be paid directly to the provider. I may be billed separately for lab services. I am responsible for knowing the details of my insurance plan (specific doctors, pre-certifications, and/or referrals. Regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past due amounts at the rate of 18% per annum (1.5% per month) until paid in full.

In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 33.3% of the principal amount(s) owing as allowed by Utah Code. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) is/ are incurred today or after today. In the event of non-sufficient funds a $25 fee will be assessed.

I am aware that my appointment is reserved for me and that missed appointments keep other patients from being seen. Patients must cancel an appointment 24 hours in advance or a cancellation fee may be assessed.

I am aware that in the event that I schedule a cosmetic appointment at Utah Valley Medical Spa and cancel or no show the appointment in less than 24 hours from the time of the appointment, I will be charged a $50 fee. A credit card will be needed in order to make an appointment in the event of a possible no show.

Notification of Billing Procedures: Please be aware that certain procedures performed in our office are not included in the standard office visit and will be billed in addition to the office visit charges (warts, molescum, moles, lesions ect). Some insurance carriers are classifying some of these procedures as surgery codes. Additionally, at the discretion of the provider, pathology may be sent for a second opinion. The patient will be billed separately by the secondary pathology services. Follow up visits may also be subject to additional office visit copay.

We code and bill for all services under the guidelines that are required according to the coding standards required by your insurance carrier.

X_____ _____ _____

Patient or Authorized Signature **(Relationship to Patient)** **Date**

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Acknowledgement of Privacy Practices--HIPAA Agreement

By signing this form, I am confirming that I have been informed of my rights to privacy regarding my Protected Health Information (PHI) to carry out Treatment, Payment, and Healthcare Operations (TPO) under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Process insurance claims, insurance applications, and prescriptions.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. I have been given the right to review and receive a copy of such Notice. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used to carry out TPO. I also understand that you are not required to agree to my requested restriction(s), but if you do agree then you are bound to abide by such restriction(s). If I do not sign this consent, Utah Valley Dermatology may decline providing treatment to me.

I have read and consent to the above information.

_____ _____ _____

Patient or Authorized Signature **(Relationship to Patient)** **Date**

I authorize Utah Valley Dermatology to release my medical and/or billing information to the following individual(s):

Name: _____ Relationship to patient: _____
Name: _____ Relationship to patient: _____

May we leave a message on your primary phone? **YES ____ NO ____**
May we send you text messages? **YES ____ NO ____**

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MEDICAL HISTORY AND INTAKE FORM

Patient: _____ Nickname:_____ DOB: _____

Primary Care Physician: _____

Reason for today's visit: _____ Date: _____

SOCIAL HISTORY:

- ❑ Smoking Status
- ❑ Current everyday smoker
- ❑ Current some day smoker
- ❑ Former smoker
- ❑ Never smoker

Occupation: _____

Employer: _____

Retired? Yes No

CURRENT OR PAST PROBLEMS WITH: (please check all that apply)

- ❑ Anxiety
- ❑ Arthritis
- ❑ Artificial joints
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ BPH (enlarged prostate)
- ❑ Crohn's Disease or Ulcerative Colitis
- ❑ Bone Marrow Transplantation
- ❑ Cancer (other than skin): _____
- ❑ COPD
- ❑ Coronary Artery Disease
- ❑ Depression
- ❑ Diabetes
- ❑ End Stage Renal Disease
- ❑ Reflux/GERD/Heartburn or Peptic Ulcers
- ❑ Hearing Loss
- ❑ Heart Attack
- ❑ Hepatitis (A, B, C)
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV/AIDS
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Immunosuppression Due to Medication
- ❑ Leukemia
- ❑ Lymphoma
- ❑ Pacemaker/Defibrillator
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ None
- ❑ Other_____

PAST SURGICAL HISTORY: (please check all that apply)

- ❑ Appendix Removed
- ❑ Bladder Surgery
- ❑ Mastectomy (Right, Left, Bilateral)
- ❑ Lumpectomy (Right, Left, Bilateral)
- ❑ Breast Biopsy (Right, Left, Bilateral)
- ❑ Breast Reduction
- ❑ Breast Implants
- ❑ Colectomy
- ❑ Gallbladder Removed
- ❑ Coronary Artery Bypass
- ❑ PTCA (procedure for blocked coronary arteries)
- ❑ Mechanical Valve Replacement
- ❑ Biological Valve Replacement
- ❑ Joint Replacement within last 2 years
- ❑ Kidney Removed (Right, Left)
- ❑ Transplant (Kidney, Liver, Heart, other)
- ❑ Ovaries Removed: (e.g. Endometriosis, Cyst, Ovarian Cancer)
- ❑ Prostate Removed: Prostate Cancer
- ❑ Prostate Biopsy
- ❑ TURP (Prostate Procedure)
- ❑ Basal Cell Cancer Surgery
- ❑ Squamous Cell Carcinoma Surgery
- ❑ Melanoma Surgery
- ❑ Spleen Removed
- ❑ Hysterectomy
- ❑ None
- ❑ Other_____

SKIN DISEASE HISTORY: (please check all that apply)

- ❑ Acne
- ❑ Actinic Keratosis (pre-cancers)
- ❑ Basal Cell Skin Cancer
- ❑ Blistering Sunburns

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- ❑ Dry Skin
- ❑ Eczema
- ❑ Flaking or Itchy Scalp
- ❑ Hay Fever/Allergies
- ❑ Melanoma
- ❑ Poison Ivy
- ❑ Precancerous Moles
- ❑ Psoriasis
- ❑ Squamous Cell Skin Cancer
- ❑ Fever Blisters/Cold Sores
- ❑ Other_____

Do you wear Sunscreen? Yes No If yes, 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)? _____

Other family history of skin disease (e.g. Basal Cell or Squamous Cell Carcinoma, Psoriasis, Eczema)

_____

CURRENT MEDICATIONS (Prescription, Non-Prescription, Vitamins, Herbs)

_____

_____

***Required Questions for Medicare Patients:**

VACCINATIONS: (Have you received any of the following) Pneumonia _____ Date _____ Flu_____ Date _____

Do you have a healthcare proxy in the event you are unable to make your own medical decisions? Yes _____ No_____

Do you have a living will? Yes____ No____

ALLERGIES to medications and type of allergic reaction (example: hives, difficulty breathing, swelling, etc.)

_____

_____

PHARMACY OF CHOICE: _____

(Name) (City)

REVIEW OF SYSTEMS: Do you have a history of any of the following or are you experiencing any of the following items currently? (Please check all that apply)

- ❑ Changing mole(s)- experiencing currently
- ❑ Rash- experiencing currently
- ❑ Fever or Chills- experiencing currently
- ❑ New/concerning skin growth
- ❑ Problems with healing
- ❑ Problems with scarring (hypertrophic or keloid
- ❑ Yeast infections with antibiotics
- ❑ GI/stomach problems with antibiotics
- ❑ History of fainting
- ❑ Problems with bleeding
- ❑ History of Accutane
- ❑ Allergy to adhesive (tape bandages)
- ❑ Allergy to topical antibiotic ointments
- ❑ History of melanoma
- ❑ History of basal cell or squamous cell cancer
- ❑ Immunosuppression
- ❑ Organ transplant
- ❑ Allergy to lidocaine
- ❑ Rapid heartbeat with epinephrine
- ❑ Currently pregnant or planning pregnancy
- ❑ Blood thinners
- ❑ Do you have a pacemaker or defibrillator

Comments or other concerns: _____

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