**INDIGO DERMATOLOGY**
**New Patient Paperwork**

**Name**: _____ **DOB**: _____

**Race**: _____ **Hispanic:** Y or N

**Street Address:** _____

**City** _____ ***State** _____ **Zip Code** _____

**Responsible party (if other than patient)**:_____

**Primary Phone**: _____ **please circle CELL WORK HOME**

**Secondary Phone**: _____ **please circle CELL WORK HOME**

Email: _____

**Marital Status**: M S W D **Spouse's Name**_____
**Employed**: Full Time, Part time, Retired, Not Employed **Employer**:
_____

***Emergency Contact** _____ **Phone#**_____

**Relation to patient:** _____

**Primary Insurance Policy Information** **Secondary Insurance Policy Information**
**□ Check here if you are Self Pay with no insurance**

**Insurance Name**_____ **Insurance Name**_____

**ID #**_____ **ID #**_____
**Group #**_____ **Group #**_____

**Address**_____ **Address**_____
**City, State, Zip**_____ **City, State, Zip**_____

**Please Note***
**Indigo Dermatology will submit claims to your insurance provider. In the event that your insurance does not pay and a balance remains on your account for services rendered, you will be billed. If your insurance coverage has a deductible, Indigo Dermatology will collect an appropriate amount at time of service, and as a courtesy we will submit claims to your insurance company to reflect that you have met some or all of your deductible.**

*****Balances and CO-PAYS must be paid at time of services*****
**Signature required to verify that you are aware of our billing and financial policies.**

Sign _____ Date _____

* ***indicates required fields***

* ***My signature and initials below indicate that I hereby give my consent to Quality Medical Care to provide medical treatment to myself or the named patient.***

INSURANCE AUTHORIZATION

My signature below indicates that I authorize Indigo Dermatology to release any pertinent medical or health information to the Social Security Administration or its intermediaries, carriers of Medical claims, or to my insurance carrier or its representative, necessary to process an insurance claim. I permit a copy of this authorization to be used in place of its original and request that payment of medical insurance benefits be made to Indigo Dermatology. Regulations pertaining to Medicare Assignment of benefits apply.

INDIGO DERMATOLOGY'S STATEMENT ON HIPAA

The Health Insurance Portability Accountability Act (HIPAA) was enacted to protect and enhance the rights of patients by providing them with access to their health information and controlling the inappropriate use of that information to reduce fraud and abuse, and to improve the quality of healthcare by restoring trust in the healthcare system.

APPOINTMENT POLICY

Appointments are reserved especially for you. Indigo Dermatology makes every effort to schedule times that accommodate your needs. Every effort is made to see all patients on time, barring any unforeseen emergencies. Indigo Dermatology asks that you make every effort to keep your appointment. If issues arise that conflict with your scheduled appointment, we ask you to call us to reschedule. Multiple missed appointments without notification make it impossible for our providers to maintain a treatment plan for our patients. Multiple "no-show, no call" for appointments may also result in a $45.00 "no show fee" applied directly to your account or a formal discharge from this practice. Your signature below indicates that you have read and agree to abide by the terms of Indigo Dermatology's Appointment Policy.

FINANCIAL POLICY

Indigo Dermatology strives to maintain a high level of professional care while keeping the costs as fair as possible. Payment is expected at the time of treatment. We accept a Check or Credit Card with proper identification such as a valid driver's license. We always accept cash. Most Health Insurance is accepted provided we can verify your eligibility for treatment by Indigo Dermatology, either before or at the time of your visit. If seeing us for primary care, it is the patient's responsibility to make sure that Indigo Dermatology is listed as their PCP with their insurance if your plan requires a PCP be selected. All CO-PAYS and/or DEDUCTIBLES are collected at time of service. If a patient does not have the appropriate co-pay or payment amount, the appointment will be rescheduled to such time as the patient can make the appropriate payment. If you are seen without payment of your patient responsibility a $10 fee will be added to the balance each month until paid. Patient is 100% responsible for all fees incurred for services rendered. We will send a claim to your chosen insurance carrier for

services rendered. If your insurance carrier does not make payment within 60 days from the date of treatment, the balance of your account will be shifted to the patient or responsible party for payment in full within 14 days. Failure to make payment or payment arrangements within 14 days may result in further collections processing.

*** My signature below indicates that I have read and agree to abide by the terms of Indigo Dermatology's Financial Policy.**

**Sign:** _____
Patient or Responsible Party Signature _____

Date _____

PHOTOGRAPHY:
Consent to medical images and / or video images being made of me or (child, if the child is the patient) not limited to one date of service. I agree that duplicates may be made for the referring doctor.

I agree that my images may be: **used by Health Professionals as part of Electronic Health Records, used by Health Professionals for education and training , used for "Before and After" purposes at the providers discretion, and used in education and marketing materials.**

I further acknowledge that there were no promises of compensation for such use of my medical photo(s) and/ or video taken by Indigo Dermatology as consented above.

*** My signature below indicates that I have read and agree to the Indigo Photography Policy.**

**Sign:** _____
Patient or Responsible Party Signature _____

Date _____

**INDIGO DERMATOLOGY HEALTH INFORMATION RELEASE FORM**

In order to assist you in receiving your health information from Indigo Dermatology, please complete this form.

I authorize the persons listed below to have access to any and all of my health information. Indigo Dermatology is permitted to:

**PLEASE CHOOSE ONE**

- o Share my medical information with the following people, including HIV, drug/alcohol abuse and psychiatric records, as well as test results and information disclosed during office visits
- o Share medical information including test results and information disclosed during office visits **not including**, HIV, drug/alcohol abuse and psychiatric records

Persons authorized to receive my medical information are:
(PLEASE DO NOT LEAVE BLANK)

FULL NAME PHONE #

_____ _____

We often deliver benign biopsy results via phone call. If you do not pick up the phone call, we request permission to leave your results on voicemail.

You may notify me or the parties listed above with normal test results, appointment reminders and other information regarding my health information as follows:

- o Message on cell voicemail_____ Phone Number:
- o Message on Home Phone/# on file _____ Phone Number:

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____
Patient – Print Name Date of Birth

_____ _____
Patient – Signature Witness – Signature

QMC Patient Account # Date

**SOCIAL HISTORY:**

1. Do you smoke?
   _____ Yes (please circle) Everyday Some days # of packs a day
   _____ No (please circle) Former smoker Never a smoker
2. What is your alcohol intake? (Please circle)
   Social Occasional Daily Never
3. How often do you exercise? (Please circle)
   Daily Weekly Monthly Never
4. What is your caffeine intake? (Please circle)
   Daily Weekly Monthly Never
5. (PLEASE CIRCLE) Are you: Married Single Divorced Widowed Long Term Partners

**Medications** (please list all medications you take including anything over the counter, aspirin, laxatives, birth control, vitamins/supplements, eye drops, creams, etc.)

| Name of Drug | Strength | How Often | Name of Drug | Strength | How Often? |
|---|---|---|---|---|---|
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**Allergies:**_____

Past Medical History:

1. Do you have problems with: bleeding? _____ healing? _____ scarring?
2. Do you have an allergy to: Adhesive? _____ Topical Antibiotic Ointment? _____ Lidocaine? _____
3. Do you take blood thinners? YES NO
4. Do you have a pacemaker or defibrillator? YES NO
5. Joint replacement: (Which joint//what year)?_____
6. Artificial Heart Valve: (What year?) _____

Please circle or answer those that apply to you below:

| | | |
|---|---|---|
| Currently Pregnant | Anxiety | Depression |
| Coronary Artery Disease | Atrial Fibrillation/Irregular Heartbeat | Heart Failure |
| Hypertension | Diabetes | Renal disease |

Organ transplant- which type?_____
Suppressed immune system- for what reason? :_____

| | | |
|---|---|---|
| Breast Cancer | Colon Cancer | Prostate Cancer |
| Leukemia | Lymphoma | Uterine Cancer |
| Lung Cancer | Other cancer: _____ | |

Hepatitis HIV/AIDS

List any other medical problems:_____

**Skin Disease History:**

| | | |
|---|---|---|
| Acne | Actinic Keratosis | Blistering Sunburns |
| Dry Skin | Eczema | Flaking/Itching Scalp |
| Precancerous Moles | Psoriasis | |

Squamous Cell Cancer Basal cell Carcinoma Melanoma Other skin cancer

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 Skin Cancer? YES NO
If yes, what relative(s): _____
Family history of pancreatic cancer or uveal melanoma YES NO

Primary Care Dr: _____ Dr's Phone # _____
Address: _____ Dr's Fax # _____

Referring Provider:_____

Pharmacy Name: _____ Pharmacy's Phone # _____
Pharmacy Cross Street or Zipcode: _____