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**New Patient Intake Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to leave message? Yes No Ok to text? Yes No

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ok to email health info? Yes No

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician and Clinic Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Responsible Party** (the insurance policy holder, if different from patient) |
| --- |

Name (write “same” if same as above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male Female

| **Referral Info** (how did you hear about Foothills Family Dermatology?) |
| --- |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had or currently have any of the following medical conditions (circle if applicable):

Arthritis COPD/Lung Disease Depression Diabetes End Stage Kidney Disease High blood pressure HIV/AIDS High Cholesterol Leukemia Lymphoma Colon Cancer Anxiety Asthma Atrial Fibrillation Stroke Coronary Artery Disease Hearing Loss Hyper or hypothyroidism Breast Cancer Lung Cancer Prostate Cancer Transplantation surgery/Organ Transplant

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any surgeries? (including joint replacement and heart valve surgeries):

Colectomy Coronary Artery Bypass Graft (CABG) Tubal Ligation Heart Valve Replacement Hysterectomy Mastectomy Hip Replacement Knee Replacement Liver Transplant Heart Transplant Kidney Transplant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have or have had any of the following skin conditions?

Acne Eczema Atypical Moles Actinic Keratosis Psoriasis Basal Cell Carcinoma Melanoma Mole Removal Squamous Cell Carcinoma Sunburn

Skin Cancer Type and Location(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a family history of melanoma (a specific type of skin cancer)? Yes No What relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications/Supplements: (including over the counter)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug Allergies:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking Status: None Current Daily Smoker Current Some Day Smoker Former Smoker

Alcohol: None 1-3 drinks per week 3-5 drinks per week 6-10 drinks per week More than 2 drinks daily

Are you currently: Pregnant Yes No

Planning Pregnancy Yes No

Breast Feeding Yes No

**FINANCIAL POLICY**

Welcome and thank you for choosing Foothills Family Dermatology for your dermatology care. Your clear understanding of your Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today’s date.  
  
Please ask if you have any questions about our fees, our policies, and/or your responsibilities.  
  
INSURANCE – When making an appointment with your physician, it is your responsibility to confirm with your insurance company that the physician is currently under contract with the plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral at the time of your appointment. If you do not have your referral at the time of your appointment, you will need to reschedule your appointment, or choose to be seen without the insurance benefits and pay for your visit in full.  
  
You are responsible for knowing your insurance benefit coverage. We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. If the insurance company does NOT pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered service, coinsurance, coordination of benefits, or pre-existing conditions. You are responsible for all copayments and deductibles at time of service.  
  
CHECK-IN: Please bring your current insurance card with you to EACH visit. Without the insurance card, we will be unable to file your insurance, and you will be responsible for all charges for that visit. On follow-up visits you will be asked to verify all demographic and insurance information so that our records remain up-to-date.  
  
CHECK-OUT: Please be prepared to pay for the current visit as well as any past balances on your account. Payment and copayments, deductibles, or fees for non-covered services will be required at the time of service. For your convenience we take cash, check, and all major credit cards.  
  
NON-COVERED SERVICES: An Insurance Waiver may be required to acknowledge understanding of your responsibility for paying for non-covered services. In dermatology, there are many procedures that are considered by Medicare and private insurers as non-covered (cosmetic in nature), including removal of skin tags, cosmetic treatment of spider veins, removal of whiteheads, as well as others. If you are coming in for a non-covered service, please be prepared to pay for the service in full.  
  
RETURNED CHECK FEES: Any returned check from the bank for non-payment shall result in the patient’s or Guarantor’s account being assessed a $25.00 fee per check.  
  
PATHOLOGY FEES & LAB TESTS: If your visit includes biopsies or lab tests these specimens are sent out for processing. You will receive separate billings from the laboratory performing the service. You are responsible to notify us if your insurance company requires particular labs for coverage of the processing.

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**Signature of Patient or Representative Date**

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**Name (Printed)** Relationship to Patient (If patient is unable to sign)

**NOTICE OF PRIVACY PRACTICES**  
  
This notice describes how your health information may be used and disclosed by Foothills Family Dermatology and how you can get access to this information. Please read it carefully.  
  
YOUR RIGHTS, UPON WRITTEN REQUEST:  
- Ask to see or get an electronic or paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible, but no later than 30 working days from the date of request.  
- Ask us to correct your health information you think is incorrect or incomplete. We reserve the right to say “no” but will tell you why in writing within 60 days.  
- You may ask us to communicate with you in a certain way (for example home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.  
- Ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree with your request and may say “no” if it would affect your care.  
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the last six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.  
- Revoke an authorization to use or disclose Protected Health Information (PHI) at any time, except where action has already been taken.  
  
YOU MAY ALSO:  
- Choose someone to act on your behalf.

- Ask for a paper copy of this document.  
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington D.C., 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints).

OUR RESPONSIBILITIES:  
- Maintain the privacy and security of your Protected Health Information (PHI).  
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.  
- Follow the duties and privacy practices described in this notice and give you a copy of it.  
- Not use or share your information other than what is described in this notice unless you tell us we can in writing.

YOUR CHOICES:  
- Share information with your family, close friends, and others involved in your care and share information in a disaster relief situation.  
- 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 your information when needed to lessen a serious and imminent threat to health or safety.

OUR USES AND DISCLOSURE:  
- Treatment: We can use your health information and share it with other professionals who are treating you.  
- Payment: We can share your health information to bill and get payment from health plans or other entities.  
- Health Care Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. We must meet many conditions in the law before we can share your information for these purposes.  
- Help with public health and safety issues: we can share health information about you for certain public health and safety issues.  
- Comply with the law: we will share information about you if state or federal law requires it, including the Department of Health and Human Services.  
- Respond to organ and tissue donation requests: We will share health information about you with organ procurement organizations.

- Address law enforcement and other government requests:  
o For law enforcement purposes or with a law enforcement official  
o With health oversight agencies for activities authorized by law  
o For special government functions such as military, national security, and presidential protective services  
o Respond to lawsuits and legal actions: We can share your health information to respond to a court or administrative order,  
or in response to a subpoena.  
o Research: we can use or share your information for health research.  
  
This notice is subject to change at any time, and changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

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**Signature of Patient or Representative Date**

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**Name (Printed)** Relationship to Patient (If patient is unable to sign)