ALBUQUERQUE DERMATOLOGY ASSOCIATES & CUTANEOUS SURGERY CENTER, PA

Please Print Legibly & Fill In or Correct All Fields

Patient's Name: _____
Last First Middle

Address _____
Street & Apt # City State Zip

Primary Phone _____ Alternate Phone _____

May we contact you by Email? ☐ No ☐ Yes E-mail _____
Birthdate _____ Age _____ SS# _____

Sex ☐ Female ☐ Male Marital Status ☐ Single ☐ Married ☐ Other

Patient's Employer: _____ Wk Ph _____ Ext:_____

Address _____
Street & Suite # City State Zip

Emergency Contact:

Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____

Mandatory: Failure to complete this section may result in cancellation/postponment of your scheduled appointment

Language_____ **Race** ☐White ☐Native American ☐African-American **Ethnicity** ☐Hispanic/Latino

☐Declined to Answer ☐Asian ☐Other_____ ☐Non-Hispanic/Latino

☐Declined to Answer ☐Declined to Answer

Person Responsible for Payment

****If patient is a minor or someone else is responsible for payment other than the patient, Please fill out the following.****

Name: _____ **Phone Number:**_____

Address (If different): _____ _____

Date of Birth:_____ **Social Security #:**_____

Primary Insurance Name: ID # Group #
Secondary Insurance Name: ID # Group #

I understand that office visit charges are payable on the day service is rendered. I authorize, Albuquerque Dermatology, to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Albuquerque Dermatology and myself. I understand that this policy will remain in effect for all services provided until I am notified of any change by Albuquerque Dermatology.

I understand that according to my insurance carrier contract, there may be co-pays and/or deductibles in addition to co-insurance amount that will be payable during the time that services are rendered. I understand that Albuquerque, Dermatology Associates and Cutaneous Surgery Center, PA have no knowledge of prepaid deductible amounts. I have been informed that Albuquerque Dermatology Associates and Cutaneous Surgery Center, PA can provide me with an **estimate** of my deductible liability at the time of my visit. I understand that these charges under the deductible owed may be significant.

In addition I have been informed of and given a copy of ADA's HIPAA private policy information brochure.

Signature _____ **Date** _____

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Albuquerque Dermatology Associates & Cutaneous Surgery Center, P.A.

MEDICAL HISTORY

This is a confidential part of your treatment and will be kept in this office. Information included on this form will not be released to anyone without written authorization from you.

DATE:_____ **NAME:**_____ **DOB:**_____
(Last) (First) (Mi)

BIRTHPLACE (city & state) _____ **Gender Identity** _____ **Preferred Pronouns**_____

Years in NM:_____ **Occupation:**_____ **Date of last exam/visit with PCP:**_____

Pharmacy/phone #: _____ **PCP/Referring Provider**_____

☐ **NO CHANGES**

AUTOIMMUNE DISEASES/TREATMENT
☐ Hashimoto's Disease _____
☐ Lupus _____
☐ Sjogren's syndrome _____
Other: _____

CARDIAC HISTORY/TREATMENT
☐ Atrial fibrillation _____
☐ CAD (coronary artery disease)_____
☐ CHF (congestive heart failure)_____
☐ Defibrillator _____
☐ Hypertension _____
☐ Hypercholesterolemia _____
☐ Myocardial infarction (heart attack) _____
☐ Pacemaker _____
☐ Other _____

ENDOCRINE/TREATMENT
☐ Diabetes mellitus I II _____
☐ Hyperthyroidism (high)_____
☐ Hypothyroidism (low) _____
☐ Other _____

GASTROENTEROLOGY/TREATMENT
☐ Celiac disease _____
☐ Crohn's disease/ulcerative colitis _____
☐ Diverticulitis _____
☐ GERD (acid reflux)_____
☐ Gout _____
☐ Hepatitis _____
☐ Irritable bowel syndrome _____
☐ Other _____

MUSCULOSKELETAL/TREATMENT
☐ Arthritis _____
☐ Osteoarthritis _____
☐ Osteoporosis _____
☐ Psoriatic arthritis _____
☐ Rheumatoid arthritis_____
☐ Other _____

PSYCHOLOGICAL HISTORY
☐ ADD/ADHD _____
☐ Anxiety _____
☐ Depression _____

PULMONARY/TREATMENT
☐ Asthma _____
☐ COPD/Emphysema_____
☐ Hayfever/seasonal allergies _____
☐ History of tuberculosis_____
☐ Lung cancer _____
☐ Pulmonary embolism _____
☐ Sleep apnea CPAP **Y** **N** _____
☐ Sinus problems/infection _____

SKIN CANCER
☐ Basal cell Carcinoma _____
☐ Melanoma _____
☐ Squamous Cell Carcinoma _____
☐ Other _____

SKIN CONDITIONS/TREATMENT
☐ Acne_____
☐ Actinic Keratosis_____
☐ Alopecia _____
☐ Asteatosis cutis (excessive dry skin) _____
☐ Atypical mole_____
☐ Eczema (atopic dermatitis) _____
☐ History of measles _____
☐ History of Scarlet fever _____
☐ History of varicella zoster/chicken pox/shingles_____
☐ Psoriasis _____
☐ Syphilis_____
☐ Vitiligo _____
☐ Warts_____
☐ Other _____

URINARY/RENAL/TREATMENT
☐ Benign prostatic hyperplasia _____
☐ Dialysis _____
☐ Kidney Disease _____
☐ Prostate cancer_____
☐ Other_____

MISCELLANEOUS/TREATMENT
☐ AIDS/HIV_____
☐ Anemia _____
☐ Breast cancer _____
☐ DVT_____
☐ Leukemia _____
☐ Lymphoma _____
Other: _____

Continued on next page

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Are you pregnant or breast feeding? _____ Do you plan on getting pregnant in the near future? _____

Have you had the influenza (flu) vaccination within the past year? **Y** **N**

Have you had the pneumococcal (pneumonia) vaccination within the past five years? **Y** **N**

Have you had the Covid-19 vaccine? **Y** **N**

Do you have a living will? **Y** **N** Do you have a DNR? **Y** **N**

Do you wear sunscreen? **Y** **N** **SPF?** _____ Sun protective clothing? **Y** **N** _____

PAST SURGICAL HISTORY

- ☐ Appendectomy (appendix)
- ☐ Cesarean (c-section)
- ☐ Cholecystectomy (gallbladder)
- ☐ Colostomy
- ☐ Coronary bypass surgery
- ☐ Coronary stent placement
- ☐ Defibrillator
- ☐ Heart Valve Replacement
- ☐ Hip Replacement L R
- ☐ Hysterectomy
- ☐ Knee Replacement L R
- ☐ Lumpectomy L R
- ☐ Mastectomy L R
- ☐ Nephrectomy (kidney removal)
- ☐ Oophorectomy (ovary removal)
- ☐ Pacemaker placement
- ☐ Prostatectomy (prostate removal)
- ☐ Transplant _____
- ☐ Other: _____

PLEASE LIST ALL CURRENT MEDICATIONS (including prescription, over-the-counter and herbal medications)
Please list name, dosage and how the medication is administered.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you require the use of coumadin (warfarin), aspirin, Plavix (clopidogrel), Pradaxa (dabigatran etexilate) or Xarelto (Rivaroxaban)? If yes, please circle.

DRUG ALLERGIES & REACTIONS

☐ **NONE**

_____ _____ _____

_____ _____ _____

SOCIAL HISTORY

☐ Non-smoker ☐ Former smoker ☐ Current smoker how much? _____ ☐ Other _____

Do you drink alcohol? Y N If yes, how many drinks do you have per day? _____< 1 _____ 1 to 2 _____ 3 or more

How many times in the past year have you had 5 or more drinks in a day (men) or 4 or more drinks in a day (women)?_____

FAMILY HISTORY (not the patient)

- ☐ Asthma if so, who? _____
- ☐ Basal Cell Carcinoma/Squamous Cell Carcinoma _____
- ☐ Eczema if so, who?_____
- ☐ Other:_____
- ☐ Hay fever if so, who? _____
- ☐ Melanoma if so, who?_____
- ☐ Psoriasis if so, who? _____

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PATIENT COMMUNICATION FORM

A. **Family and Friends** It is the office policy of Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient.

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (✓) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing.)

Spouse: _____ **yes** _____ **no** _____

Parent: _____ **yes** _____ **no** _____

Other: _____ **yes** _____ **no** _____

_____ **yes** _____ **no** _____

_____ **yes** _____ **no** _____

B. **Alternative Communications** You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

_____

PRINTED NAME: _____

Relationship to Patient: _____

Patient/Parent/Guardian Signature:_____

Date: _____ **Witness:** _____

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you; however, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by:_____
Printed Name - Patient or Representative

Signature: _____

Relationship to Patient (if other than patient): _____

In front of _____**Date:** _____
Printed Name - Practice Representative

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Pathology Policy

Dear Patients:

For all patients who will be having a **BIOPSY** done, there is an **ADDITIONAL** pathology fee to process the tissue from the biopsy in our facility. The front desk will give you the total charges including a minimum charge of $253.00 for your biopsy and $126.00-$235.00 for the pathology with further charges for any additional procedures that are done.

Sometimes, an initial review of your biopsy indicates that further, more in-depth testing will be required to reach the correct diagnosis, possibly from an outside laboratory. In this case, supplementary charges ranging from $140.00 to $1,000.00 (in rare circumstances) will be assessed. You are responsible for any charges that are not covered by your insurance company.

There has been some confusion among our patients regarding charges for pathology. We hope we have provided proper information to our patients regarding charges incurred for these services. If you have any questions, please let us know.

Sincerely,

The physicians and staff at Albuquerque Dermatology Associates & Cutaneous Surgery Center, P.A.

_____

Patient Signature (or Parent's Signature if Minor) **Date**

General Financial Policy

I have received Albuquerque Dermatology's General Financial Policy. I understand that charges not covered by my insurance (pathology, office visits, additional surgical and non-surgical procedures, cosmetic procedures), as well as applicable co-payments and deductibles are my responsibility. I authorize my insurance benefits be paid directly to Albuquerque Dermatology Associates and I authorize them to release any pertinent medical information to facilitate payment of a claim. I understand that any payment required for cosmetic procedures must be paid at the time of service.

I understand that these policies will remain in effect for all services provided until I am notified of any change by Albuquerque Dermatology Associates & Cutaneous Surgery Center, P.A.

_____

Patient Signature (or Parent's Signature if Minor) **Date**

WRITTEN ACKNOWLEDGMENT FORM

I am a patient of Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA. I hereby acknowledge receipt of Albuquerque Dermatology Associates & Cutaneous Surgery Center, PA's Summary of Privacy Practices and Notice of Privacy Practices.

Name (please print): _____Date:_____

Signature: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Albuquerque Dermatology Associates and Cutaneous Surgery Center, PA's Summary of Privacy Practices and Notice of Privacy Practices with respect to the patient.

Name (please print): _____Date:_____

Relationship to patient:_____

Signature: _____