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** _____

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:**_____

BIRTHPLACE (city & state) _____ **Years in NM:**_____ **Occupation:**_____

Pharmacy/phone #: _____ **Primary Care Provider:**_____

Cardiologist: _____ **Oncologist:** _____

Other Specialty Provider (s):_____

AUTOIMMUNE DISEASES
- ☐ Hashimoto's Disease
- ☐ Lupus
- ☐ Sjogren's syndrome

Other: _____

CARDIO-VASCULAR HISTORY/DATE OF DIAGNOSIS
- ☐ Atrial fibrillation _____
- ☐ CAD (coronary artery disease)_____
- ☐ CHF (congestive heart failure)_____
- ☐ Defibrillator _____
- ☐ Hypertension _____
- ☐ Hypercholesterolemia _____
- ☐ Myocardial infarction (heart attack) _____
- ☐ Pacemaker _____
- ☐ PVD (Peripheral Vascular Disease) _____
- ☐ Stroke _____
- ☐ TIA (Transient Ischemic Attack) _____
- ☐ Other: _____

ENDOCRINE
- ☐ Diabetes mellitus I II
- ☐ Hyperthyroidism (high) ☐ Hypothyroidism (low)
- ☐ Other: _____

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

MUSCULOSKELETAL
- ☐ Osteoarthritis (Arthritis)
- ☐ Osteoporosis
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis
- ☐ Other: _____

PULMONARY/TREATMENT
- ☐ Asthma
- ☐ COPD/Emphysema
- ☐ Hayfever/seasonal allergies
- ☐ History of tuberculosis
- ☐ Lung cancer
- ☐ Pulmonary embolism
- ☐ Sleep apnea CPAP **Y** **N**

SKIN CANCER/Date of diagnosis and/or treatment
- ☐ Basal cell Carcinoma_____
- ☐ Melanoma_____
- ☐ Squamous Cell Carcinoma _____
- ☐ Other:_____

SKIN CONDITIONS
- ☐ 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
- ☐ Benign prostatic hyperplasia
- ☐ Dialysis
- ☐ Kidney Disease
- ☐ Prostate cancer
- ☐ Other:_____

MISCELLANEOUS
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Breast cancer
- ☐ DVT
- ☐ Leukemia
- ☐ Lymphoma

Other: _____

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

Continued on next page

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

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

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

Do you have an Advanced Care Plan/Medical POA? If yes, name: _____ **N**

PAST SURGICAL HISTORY

- ☐ Appendectomy (appendix)
- ☐ Cesarean (c-section)
- ☐ Cholecystectomy (gallbladder)
- ☐ Colostomy (opening in stomach)
- ☐ 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 if so, who? _____
- ☐ Eczema if so, who?_____
- ☐ Hay fever if so, who? _____
- ☐ Melanoma if so, who? _____
- ☐ Psoriasis if so, who? _____
- ☐ Other:_____

Medical Records Release

Albuquerque Dermatology Associates and Cutaneous Surgery Center, P.A.
5310 Homestead Road NE Ste. 301
Albuquerque, NM 87110

Phone: 505-872-4700
Fax: 505-872-4709
Email: adrecords@swcp.com

Section I--Patient Information

Name:_____ **DOB:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone:_____**Email:**_____

I, or my authorized representative, hereby authorize **Albuquerque Dermatology Associates & Cutaneous Surgery Center** and their respective employees, agents and subcontractors to disclose/receive my Personal Health Information (PHI) and Insurance Record as below:

Section II--Provider Information

INFORMATION REQUESTED FROM:

Name:_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone:_____**Fax:**_____

SEND INFORMATION TO:

Name:_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone:_____**Fax:**_____

Section III–Information to be Released

Office notes:_____ **Biopsy reports:**_____

Laboratory studies:_____ **Surgical procedures:**_____

Allergy test/treatment:_____ **Other:**_____

Treatment dates ranging from _____**to** _____

HIV-Related Information:_____

Entire record (excluding medical records sent to ADA/CSC by outside health care providers**):**_____

Section IV–Reason for Release of Records

Continuing care:_____ **Transfer of care:**_____

Insurance application*:_____ **Personal use*:**_____

Other: _____ *** A fee may be charged**

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE**, **SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION** only if I place my initials on the appropriate line in Section III. In the event the health information described below includes any of these types of information, and I initial the line on the box in Section III, I specifically authorize release of such information to the person indicated in Section II.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization.

3. I have the right to revoke this authorization at any time by writing to ADA/CSC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in ADA/CSC, or eligibility benefits will not be conditioned upon my authorization of disclosure.

5. This authorization does not authorize you to discuss my personal health information and insurance record with anyone other than the person authorized in section II.

6. Information disclosed under this authorization might be re-disclosed by the recipient, and the re-disclosure may no longer be protected by federal or state law.

This authorization will expire (date) _____. I understand that if I do not specify an expiration date, this authorization will expire 12 months from the date on which it was signed.

_____

Signature of Individual or Personal Representative Authorized by Law Date

If signed by Personal Representative, basis of authority:_____

For ADA/CSC use only:

_____

Signature of Medical Records Clerk

_____

Date

Records Released

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

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:** _____

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

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

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

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: _____