K2 Dermatology Clinic
3434 47th St. Suite 200 Boulder, CO 80301
Phone: 303-444-8100 Email: admin@k2derm.com

Patient Registration Form

Patient's Name _____

Mailing Address _____

ZIP Code_____City_____State_____

Date of Birth mm/dd/yy_____SSN_____

Email Address_____

Primary Phone_____ Select One ◯ Home ◯ Cell ◯ Business

Secondary Phone _____ Select One ◯ Home ◯ Cell ◯ Business

Gender, Select One: ◯ Male ◯ Female ◯ Other

Marital Status, Select One: ◯ Single ◯ Married ◯ Widowed ◯ Domestic Partner

Employment Status, Select One: ◯ Employed ◯ Not Employed ◯ Retired ◯ Student

Employer_____ Phone_____

Emergency Contact _____ Phone_____

Relationship to Emergency Contact_____

May we leave personal medical information on your answering machine or cell phone? ◯ Yes ◯ No

Primary Care Physician (PCP)_____

Preferred Pharmacy Location _____

Primary Insurance Company _____

Member ID#_____Group#_____

Name of Primary Insured_____Date of Birth mm/dd/yyyy _____

Address of Primary Insured_____

City_____State_____ZIP_____Phone Number_____

Secondary Insurance Company_____

Member ID#_____Group#_____

Name of Primary Insured_____DOB: mm/dd/yyyy_____

Address of Primary Insured_____

City_____State_____ZIP_____ Phone Number:_____

By signing below, I acknowledge that the above information is correct. I am also authorizing the billing of the above mentioned insurance company(s).

Patient Signature (Parent if minor)_____Date mm/dd/yy_____

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Medical History Form

Name: _____ DOB: _____ (mm / dd / yy) Today's Date: _____ (mm / dd / yy)

Reason for today's visit:

_____

Medical history: Please indicate all medical conditions or diseases you have now, or have had in the past:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplant
- ☐ BPH (Enlarged Prostate)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

List any other diseases or conditions:

_____

List surgical procedures you have had in the last 6 months:

_____

List all other major surgeries in your lifetime:

_____

Have you ever received anesthesia/numbing at the dentist? ◯YES or ◯NO

Any adverse reaction? ◯YES or ◯NO

Do you require antibiotics prior to dental or medical procedures? ◯YES or ◯NO

(Women) Are you currently pregnant or planning a pregnancy? ◯YES or ◯NO

Due Date: _____ (mm / dd / yy)

Skin/Dermatology History:

Have you ever had skin cancer? ◯YES or ◯NO

Type & location? _____

Do you have a history of any other skin conditions? ◯YES or ◯NO

Type? _____

Do you or have you used tanning beds? ◯YES or ◯NO

Do you have problems with healing? ◯YES or ◯NO

Do you bleed easily? ◯YES or ◯NO

Do you develop skin rashes in reaction to any of the following? (Please check if YES):

☐Medication ☐Food ☐Environment
☐Bandages ☐Topical Neosporin ☐Other _____

Family History:

Has anyone in your family had melanoma? ◯YES or ◯NO Who? _____
Other skin cancer (basal or squamous)? ◯YES or ◯NO Who? _____
Any family history of other skin conditions? ◯YES or ◯NO Who? _____

Medications: List all current prescriptions, over-the-counter meds, vitamins, herbs and supplements:

_____
_____
_____
_____

Allergies:

Are you allergic to any medications? ◯YES or ◯NO
If yes, please list medications and your reaction:

_____
_____
_____
_____

Social History:

Do you use tobacco products?

◯never ◯formerly ◯currently Type/amount per day? _____

Do you drink alcohol? ◯YES or ◯NO

How much per day? ◯less than 1 drink ◯1-2 drinks ◯3 or more drinks

Do you use recreational/illicit drugs? ◯YES or ◯NO

If YES, what? _____ How often? _____

What is your occupation? _____

Hobbies?_____

_____

Patient signature (Parent / Legal guardian signature, if patient is under 18)

IBK012725

Reviewed by: Date:

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NOTICE OF PATIENT PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

EFFECTIVE DATE OF THIS NOTICE: January 1, 2015

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF K2 DERMATOLOGY CLINIC) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION
PLEASE READ THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY:
Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of legal duties and the privacy practices that we maintain in our practice concerning your PHI. By Federal and State Law we must follow the terms of the privacy practices that we have in effect at the time.

We realize that these laws can be complicated but are required to provide you with the following information:

1) How we may use and disclose your PHI.
2) Your privacy rights in your PHI.
3) Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that we may create or maintain in the future. Our practice will post a copy of our current Notice on our website and in our office in a visible location at all times, and you as the patient may request a copy of our current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT:
The Practice Manager at our location is Ivy B. Koger, HIPAA Privacy Official for K2 Dermatology Clinic, telephone number 303-444-8100.

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

Treatment. The information in your medical records will be used to determine which treatment options best addresses your health needs. The treatment selected will be documented in your medical records so that other health care professionals can make informed decisions about your care. For example, we may request you have laboratory tests and we may use the results of those test to reach a diagnosis. Many of the people who work for our practice, including but not limited to our healthcare providers and staff, may use or disclose your PHI in order to treat you or assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse,

children, or parents. Finally, we may also disclose your PHI to other healthcare providers for purposes related to your treatment.

Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services, treatments, and products you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and the range of benefits), and we provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay, your treatment. We may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services, treatments and other items. We may disclose your PHI to other healthcare providers and entities to assist in their billing and collection efforts.

Health Care Operations. Our practice may use and disclose your PHI to operate our business, and may use your PHI to evaluate the quality of care you received from us, or to conduct cost management and business planning activities for our practice. We may disclose your PHI to other healthcare providers and entities to assist in their healthcare operations.

Appointments and Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment or as a follow up on treatment or services performed. This contact may be via telephone, in writing either by letter or post card, e-mail, or by leaving a message on your answering machine, which could (potentially) be picked up by others.

Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options and alternatives. We may treat you in an open treatment area and some incidental PHI may be overheard by other patients being treated at the same time.

Health Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you. For example, we may send you newsletters that may include information about our practice, health related issues, and products and services.

Release of Information to Family and/or Friends. Our practice may release your PHI to a family member or friend that is involved in your care or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take your child to our office for treatment of a wart. in this example, the babysitter may have access to your child's medical information.

Disclosure Required by the Law. Our practice will use and disclose your PHI when we are required to do so by Federal, State or Local Law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your protected health information:

Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

A. maintaining vital records, such as births and deaths;
B. reporting child abuse or neglect;
C. preventing or controlling disease, injury or disability;
D. notifying another person regarding potential exposure to a communicable disease.

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Receipt of Notice of Patient Privacy Practices (HIPAA)

I, (patient name) _____ have read a copy of K2 Dermatology Clinic's Notice of Patient Privacy Practices.

Name of person(s) with whom we may discuss your information	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Patient Signature (Parent if minor) Date mm / dd / yy

The above authorization can be revoked, in writing, at any time.

Financial Policy/Patient Waiver Agreement

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Please Note: Complete insurance and personal information is required at the time of your appointment in order for our office to file a claim to your insurance company.

Your Insurance Policy is an agreement between you and your insurance company. It is ultimately your responsibility to verify the coverage and benefits of your Insurance Policy prior to your appointment. Furthermore, all charges are ultimately your responsibility, regardless of your insurance status. Questions regarding your insurance coverage and benefits should be directed to your health insurance provider.

ONLY if any of the following apply, indicate below, then sign and date on the bottom line.

☐ **I do not have Health Insurance** – I certify that I do not have medical insurance coverage of any kind, including Medicaid, and I am responsible for all charges due to me at the time of my appointment.

☐ **I cannot provide my insurance information at this time** - I understand if I don't produce a valid insurance card within (5) business days of my appointment I will be financially liable for payment in full. In lieu of a payment in full, a valid credit card will be kept on file. If, at the end of (5) business days, K2 Dermatology has not received a copy of my valid insurance card, I will be charged for all balance(s) resulting from this appointment.

☐ **My insurance requires a Referral, but I do not have one** – I understand that it is my responsibility to obtain a referral from my Primary Care Physician if my Insurance Policy requires it, but I cannot provide that referral at this time. I also understand that it is my responsibility to ensure that any required referral is completed and recorded by the day of my appointment in order for my insurance to be billed. If a referral is not received for any reason by the day of this appointment, I understand that I will be financially liable for the full amount for all charges related to this visit.

Though K2 Dermatology may be a contracted provider with my insurance company, I understand that some or all of the services which are requested and rendered may not be deemed a "covered" service under my particular plan. I am responsible to pay K2 Dermatology for any copayment as instructed by my insurance company, any unsatisfied deductible, co-insurance or termination of coverage, and any amount considered non-covered by my insurance company. Should my insurance company or any benefits provided by that insurance company change, I will immediately notify K2 Dermatology of said changes.

By signing this agreement, I acknowledge that I will be liable for all costs (including legal costs), charges, commissions, fees, and disbursements incurred by K2 Dermatology in the attempt to recover any unpaid account, including charges for any dishonored checks or credit card payments. If K2 Dermatology deems it necessary to use a collection agency or attorney to collect money owed by me, I agree to pay the collection costs, fees, and commissions which are assessed by the collection agency or attorney.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

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Credit Card on File Authorization

As our patient, you have our commitment to provide quality care and services. As your medical provider, we need your commitment to provide prompt payment for these services.

As a courtesy to you, we will bill your insurance company for the services you received today. We request to have your credit card information on file as a deposit for your service. Your card will be automatically charged only after your insurance company has processed your claim.

All charges that are not covered by insurance, including co-pays, deductibles, and co-insurance will be charged to your credit card. Co-pays are due at the time of service.

Please contact our office with any questions at 303-444-8100 or admin@k2derm.com.

I authorize K2 Dermatology Clinic, PC, to charge any outstanding balances to the credit card, debit card, or HSA/FSA card listed below.

Patient Name:

_____

○ Visa ○ Mastercard ○ Discover ○ Amex

Card Number:

_____

Expiration Date: _____ Security Code (CVV): _____

Zip Code:_____

Card Holder Name (PRINT)

_____

Signature _____ Date _____
mm / dd / yy