Name:____ **Date:**________________

We would like to know how you he ard about us…

Please circle one of the following:

- Yahoo
- Phonebook: ______________________________
- Google
- Previous Patient Who? ________________________________
- Friend/ Relative Who? ________________________________
- Doctor ____
- Insurance ____
- Walk-In/ Drive By
- Facebook
- Instagram
- Mailers
- Other ____

Frontier Skin & Cancer

Patient Information Form

Name ____ Date ____________

First Middle Last

Address ______________________ City ______________ State ________ Zip ________

Cell # __________ Home phone __________ Soc. Security # ______________ Birthdate __________

Email ____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If college student, F.T/P.T., name of school ______________________ City __________ State ________

Patient or parent's employer ______________________ Work phone ______________

Business address ______________ City ______________ State ________ Zip ________

Spouse or parent's name ______________ Employer ______________ Work phone ______________

Whom may we thank for referring you ____

Person to contact in case of an emergency ______________________ Phone ______________

Responsible Party

Name of person responsible for this account ______________________ Relationship to patient ______________

Address ____ Home phone ______________

Birth Date ______________ Soc. Security # ______________

Employer ____ Work phone ______________

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured ____ Relationship to patient ______________

Birthdate ______________ Soc. Security # ______________

Name of employer ______________ Union or local # ______________ Work phone ______________

Employer address ______________ City ______________ State ________ Zip ________

Insurance Co. ______________ Tel. # ______________ Grp. # ________ Policy/I.D.# ________

Do you have any additional insurance ☐ Yes ☐ No If yes, complete the following:

Name of insured ______________ Soc. Security # ______________ Date employed ______________

Name of employer ______________ Work phone ______________

Employer address ______________ City ______________ State ________ Zip ________

Insurance Co. ______________ Tel. # ______________ Grp. # ________ Policy/I.D. # ________

Ins. Co. address ______________ City ______________ State. ________ Zip ________

I authorize release of my medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature ______________________________ Date ______________

Name____Date of Birth__________ Date_______

WHAT IS THE REASON FOR YOUR VISIT TODAY?____

____

____

ALLERGIES:____

____

DERMATOLOGIC HISTORY: Do you have a history of:

1. □ Melanoma
2. □ Squamous Cell Carcinoma
3. □ Basal Cell Carcinoma
4. □ Skin Cancer, Uncertain Type
5. □ Dysplastic (Atypical) Moles
6. □ Actinic Keratosis (Pre-cancer)
7. □ Eczema
8. □ Psoriasis

Other______________________________________

FAMILY HISTORY: Do family members have a history of any of the following?

1. □ Melanoma (if yes who____________________)
2. □ Squamous Cell Carcinoma
3. □ Basal Cell Carcinoma
4. □ Skin Cancer, Uncertain Type
5. □ Dysplastic (Atypical) Moles)
6. □ Eczema/Psoriasis

Other______________________________________

SURGICAL HISTORY

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____

SOCIAL HISTORY

1. **Alcohol:** Y / N
2. **Smoking:** Y / N
3. **Lifetime sun exposure:** Light Medium Heavy
4. **Current sun exposure:** Light Medium Heavy
5. **Pneumonia Vaccine:** Y / N
6. **Living will or Advance Care plan:** Y / N

MEDICATIONS: please list current medications

Skin Medications

1.____
2.____
3.____

Other medications

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8.____

□ SEE LIST

Pharmacy: ______________________________

Cross roads: ______________________________

RACE: (circle one) American Indian or Alaskan Native Asian African American

Caucasian Hispanic Native Hawaiian or Pacific Islander Other Decline

LANGUAGE:

English Spanish Other:

<u>Payment Policy</u>

1. **We do not accept checks for any amount!**
2. Cosmetic Procedures must be paid for in cash or by credit card before services are rendered.
3. No refunds will be issued; **All payments are final.**
4. **All Product sales are final, no returns.**

<u>Cancellation Policy</u>

A $50.00 cancellation fee will apply to appointments not cancelled 24 hours prior to their scheduled time. This fee pertains to all **Appointments. The $50 fee must be collected prior to scheduling the next appointment.**

____
Please PRINT Patient's Name Date

____
Patient/ Parent/ or Legal Guardian's Signature Date

<u>Post-op Care Policy</u>

Services that are performed that are paid with a credit card, debit card or with financing are not eligible for post-op care payment. The practice encourages a complete post-op care and follow-up interaction to address any issues that may arise, which are further addressed in the Revision Policy. Health care regulations concerning patient privacy acts must be honored. Our office will not share any health information with your bank. I agree that this credit, debit card or financing challenge agreement is irrevocable.

Patient name (Print):____

Patient Signature: ____

Date: ___________________________

TO ALL PATIENTS WITH INSURANCE COVERAGE

PLEASE READ AND SIGN

If you have insurance coverage, it is your responsibility to know the policy and guidelines of that company. What this means is, you are responsible to know your deductible, co-pay, type of coverage, and whether or not you need an authorization to be seen at this office. If we are not your primary care physician, most companies require you to have a written authorization before seeing any other doctor. This is why it is important that you notify us before doing so.

With so many different insurance policies around, it is virtually impossible for this office to know the details of every insurance policy. We will try to help you as much as possible, but should your insurance deny your bill, you will be held liable for any charges.

I, ____, have been informed by my physician or a
(Last name) (First name)
representative of Frontier Skin and Cancer that I will be responsible for services provided that are deemed medically unnecessary by insurance company.

IMPORTANT! If you have an HMO or Managed Care Plan, you must have an authorization to be seen. If we do not have an authorization, you will not be seen by the doctor.

If we can answer any questions, or assist you in any way, we will be happy to do so.

Thank you.

____
Please PRINT Patient's Name

____ ________________
Patient or Responsible Party's Signature Date

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompletely rendered, will be determined by submission to arbitration provided by Arizona law, and not by a lawsuit or resort to court process except as Arizona law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute in a court of law before a jury, and instead are accepting the use of binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against a Physician, including any fee dispute, whether or not the subject of any existing court action shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing-the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Arizona Revised Statutes (ARS) 12-1501-12-1518 and the Federal Arbitration Act (9 U.S.C 1-4), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with Arizona and federal law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________________
Physician or Duly Authorized Representative Signature (Date)

By: ______________________________
Patient's Signature (Date)

By: ______________________________
Print or Stamp Name of Physician, Medical Group or Association Name

By: ______________________________
Print Patient's Name

By: ______________________________
Signature of Translator (If applicable) (Date)

By: ______________________________
Patient's Representative's Signature (Date)

By: ______________________________
Print Name of Translator

By: ______________________________
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL RECORDS

I hereby authorize the physicians or employees of _______________________________ to forward my medical records.

DURATION: *Authorization shall be effective immediately and remain in effect for one year.*

REVOCATION: *Written revocation will be effective upon receipt.*

SPECIFY RECORDS:

Check the box and initial which type of information is to be disclosed:

- ☐ Progress Notes
- ☐ Pathology Reports/ Lab Results
- ☐ MOHS notes/ MOHS map cards
- ☐ ______________________________

Please provide records in the following format:

- ☐ FAX
- ☐ PAPER RECORD
- ☐ EMAIL

PLEASE PROVIDE RECORDS FROM THE FOLLOWING SERVICE DATES:

____

RELEASE MEDICAL RECORDS FROM:

Doctor/Clinic: ____

Address: ____

City/State/Zip: ____

Telephone Number: ____ Fax: ____

FORWARD MEDICAL RECORDS TO:

Doctor/Clinic: **FRONTIER SKIN AND CANCER CLINIC**

Address: **1951 MESQUITE AVE. STE F**

City/State/Zip: **LAKE HAVASU CITY, AZ 86403**

Telephone Number: **928-963-9333** Fax: **928-361-2611**

☐ **Under Federal Regulations known as HIPAA, patients may be charged a copying fee. Frontier Skin and Cancer charges .60 cents per page for medical records forwarded to an attorney, insurance company, or for personal use. There will be no charge for records transferred to another physician.**

PATIENT NAME: ____ **DOB:** ______________________________

PATIENT SIGNATURE: ____ **DATE:** ______________________________

I,____________________________ (DOB)_____________, give Frontier Skin and Cancer and staff, authorization to disclose my protected health information to the following family, friends and/or caregivers:

Name:__________________________________Relationship:______________Phone:___________________

Name:__________________________________Relationship:______________Phone:___________________

Name:__________________________________Relationship:______________Phone:___________________

Name:__________________________________Relationship:______________Phone:___________________

In the event Frontier Skin and Cancer may need to give your test results or medical information may we.........(check all that apply)

_____ Leave a detailed voice message on this phone, the number is __________________

_____ Call you on your cellular phone, the number is__________________

_____ Call you at work, the number is __________________

_____ Speak to you directly. **ONLY**

Disclaimer: Certain Sensitive health information (treatment / testing) are specifically protected and will not be disclosed outside of the clinic setting without specific authorization. This includes the following:

• Mental / behavioral Health records • Sexually transmitted disease (STD) • HIV testing results / AIDS treatment

Please indicate if you allow or deny Frontier Skin and Cancer the ability to share this information with you, per the indicated communication option above.

I allow Frontier Skin and Cancer to share sensitive health information as noted above per the communication options checked on this form. ______________________________ (Patient Signature)

I DO NOT allow Frontier Skin and Cancer to share sensitive health information as noted above.
______________________________ (Patient Signature)

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Medical Records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. Frontier Skin and Cancer and its entities will not condition treatment, payment, enrollment, or eligibility for benefits on providing, or refusing to provide this authorization . I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices, which I obtained from my doctor's office.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify a date, this authorization will expire one (1) year from the signature on this form.

____Date___________________________

Signature of Patient

____Date___________________________

Signature of Guardian or Personal Representative

____Date___________________________

Signature of Frontier Skin and Cancer Employee