

Main Clinic
1618 S Millennium Way Ste 100
Meridian ID 83642
(208) 884-3376



Ten Mile Clinic
4574 N Ten Mile Rd Ste 120
Meridian ID 83646
(208) 884-3376

ADULT PATIENT INFORMATION

Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security #: _____ Driver's License #: _____

Birth Gender: Male Female Gender Identity: _____

Marital Status: Single Married Separated Divorced Widow

DEMOGRAPHIC & CONTACT INFORMATION

Preferred Language:	Race:
English	Decline to Specify
Spanish	White
Other:	American Indian or Alaska Native
	Asian
	Black or African American
	Other:

Preferred Appointment Reminder: Phone Email Text Decline Reminders

Emergency Contact: _____ Relationship: _____ Phone: _____

Patient Home Phone: _____ Patient Work Phone: _____ Patient Mobile Phone: _____

Is it okay to leave a detailed message on your answering machine/voicemail if you are unavailable? YES NO

Email Address: (please PRINT clearly): _____

Mailing Address: _____
(Street or PO Box) (City) (State) (Zip)

Preferred Pharmacy: Name: _____ Street: _____ City: _____

Primary Care Physician: Last Name: _____ First Name: _____

Check here if you are uninsured (skip insurance information)

INSURANCE INFORMATION (Please fill out completely)

Primary Insurance		Secondary Insurance	
Policy or ID Number		Policy or ID Number	
Policy Holder's Name	Relationship to Patient	Policy Holder's Name	Relationship to Patient
Policy Holder's Social Security #	Policy Holder's Date of Birth	Policy Holder's Social Security #	Policy Holder's Date of Birth
Policy Holder's Employer		Policy Holder's Employer	

Patient Name: _____

DOB: _____

Check here only if you are uninsured, meaning you do not carry or have insurance. Read the policies & sign below.

POLICIES FOR TREATMENT

ASSIGNMENT OF BENEFITS: I hereby assign all applicable benefits and direct that payment be made directly to Ada West Dermatology for all services provided to/for me during my visits.

RELEASE OF INFORMATION: I authorize Ada West Dermatology to furnish medical and other information necessary to process claims on my behalf. This information may be released to my personal physician and, upon request, to any other healthcare provider who may need the information for continuity of care. This release of information will remain in effect until revoked by me in writing.

MEDICATION HISTORY CONSENT: By signing below, I authorize Ada West Dermatology to access my relevant pharmacy prescription data (including medication history from other medical providers) electronically through Sure-Scripts or similar programs.

TREATMENT AUTHORIZATION: The patient willfully requests treatment and consents to services provided by, or at the direction of the physicians, their physician assistants, or their nurse practitioner.

NOTICE OF PRIVACY PRACTICES: As required by law, I have been given a copy of the Notice of Privacy Practices followed by Ada West Dermatology.

FINANCIAL POLICY

Ada West Dermatology is committed to providing quality medical services at reasonable cost. In order to ensure effective communication between you and our practice, we have adopted the following financial policy. If you have any questions concerning this policy, please discuss them with our billing department.

Please provide a current copy of your insurance card. If proof of insurance is not provided, you will be required to make payment in full. Co-pay, co-insurance and deductibles will be collected at check out. Ada West Dermatology will submit your claim to your insurance company for all charges incurred at the time of service.

Patients *with insurance coverage* are responsible to understand the specifics of their individual insurance policies. The patient retains ultimate responsibility for financial charges. Please contact your insurance company at the phone number provided on the back of your insurance card for your policy details.

Patients *without insurance coverage* are responsible for financial charges. We require payment of services prior to the visit and/or procedure. Uninsured patients are required to make payment at check-in. At check-out, the full balance is due for additional charges.

We may provide services in our facility, such as blood work or pathology, that are sent to outside sources. If your insurance requires specific providers of service to be used, or if you have any questions regarding the cost of service, please notify a staff member before services are rendered. After your insurance company processes the claim, you may receive the following additional charges: Office visit co-pay, Charges for procedures performed by the provider, Pathology costs, and Additional pathology tests.

We require payment of co-payment, deductibles and co-insurances at time of visit and/or procedure upon check-out. If this is not possible, please discuss this with our billing department before services are rendered. If you are unable to make your payment at check-in, you may be asked to reschedule your appointment.

I understand and agree that I am responsible for payment of all charges, including those not paid by my insurance, in a reasonable time. Small balance credits of less than \$1.00 will be written off of my account. Unpaid balances over 30 days will accrue 1.5% interest monthly.

No Show fees: Appointment no-shows or cancellations less than 24 hours in advance will be charged \$35.

If there are any questions or concerns about cost of services, please ask to speak with a member of our billing department. We are very sensitive to your individual financial constraints. If necessary, we encourage patients to contact our billing department to arrange an acceptable payment schedule. **PLEASE NOTE:** An outstanding balance greater than 90 days will be sent to an outside agency for collection.

I have read and understand the treatment and financial policy. I certify that all my questions have been answered to my satisfaction.

Signature of Patient or Representative: _____ **Date:** _____

Personal Representative Name: _____ **Authority:** _____

(If signed by the patient's Personal Representative, please **print name** and describe authority to act for the individual)

Ada West DERMATOLOGY

Patient Name:	DOB:
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Past Medical History: (please check NONE or check all that apply) NONE

Anxiety	Diabetes	Hypothyroidism (Underactive Thyroid)
Arthritis	Elevated Blood Pressure	Leukemia
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation	GERD (Gastroesophageal Reflux Disease)	Radiation Therapy
CAD (Coronary Artery Disease)	Hepatitis (A, B, or C)	Seizure
Cancer Type:	HIV/AIDS	Stroke
COPD (Chronic Obstructive Pulmonary Disease)	Hypercholesterolemia (High Cholesterol)	
Depression	Hyperthyroidism (Overactive Thyroid)	

Other: _____

Past Surgical History: (please check NONE or check all that apply) NONE

Coronary Artery Bypass	Hysterectomy (Uterus Removal)	Replacement of Knee Joint (Left, Right, Both)
Bone Marrow Transplant	Mastectomy (Breast Removal) (Left, Right, Both)	Transplant: _____
Colectomy (Colon Removal)	Nephrectomy (Kidney Removal) (Left, Right)	Tubal Ligation
Excision of Melanoma	Oophorectomy (Ovary Removal) (Left, Right, Both)	
Heart Valve Replacement	Replacement of Hip Joint (Left, Right, Both)	

Other: _____

Skin Disease History: (please check NONE or check all that apply) NONE

Acne	Blistering Sunburn	Malignant Melanoma
Actinic Keratosis	Dry Skin	Precancerous Moles
Basal Cell Carcinoma	Eczema	Psoriasis
Biopsy of Skin	Flaking or Itchy Scalp	Squamous Cell Carcinoma

Other: _____

Do you wear sunscreen? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, what SPF? _____
Do you <u>currently</u> tan in a tanning bed? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have a family history of Melanoma Skin Cancer? <input type="checkbox"/> YES <input type="checkbox"/> NO
If YES, which relative(s)? _____
(Melanoma ONLY, not Basal Cell Carcinoma or Squamous Cell Carcinoma)

Ada West DERMATOLOGY

Patient Name:	DOB:
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Medications: (Please list all current medication information, or attach a current medication list) NONE

Name	Strength	How Many?	How Often?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Allergies: (Please list all allergies) NONE

1
2
3
4

5
6
7
8

Occupation: _____

Immunizations:

Patients 18 years or older: Most recent influenza immunization? Date:	Pneumonia vaccination for patients 65 years or older. Have you received your pneumonia vaccination since you turned 60? <input type="checkbox"/> YES <input type="checkbox"/> NO
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Alerts: Do you have any of the following? (Please mark yes or no)

Alert:	Yes	No	Alert:	Yes	No
Allergy to Latex			Blood Thinners		
Allergy to Adhesive			MRSA		
Allergy to Lidocaine			Pacemaker		
Allergy to Topical Antibiotic Ointments			Premedication Prior to Procedures		
Artificial Heart Valve			Rapid Heartbeat with Epinephrine		
Artificial Joints Within Past Two Years			Pregnancy or Planning a Pregnancy		

Patient Name: _____	DOB: _____
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Authorization to Disclose Protected Health Information

I hereby authorize Ada West Dermatology to disclose the specific information described below only for the purpose(s) and to the individual's also described below.

Description of the specific information to be disclosed:

- | | | |
|--|--|---|
| <input type="checkbox"/> Appointment Information | <input type="checkbox"/> Imaging | <input type="checkbox"/> Billing |
| <input type="checkbox"/> Visit or Progress Notes | <input type="checkbox"/> Diagnosis/Care Plan | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Lab Tests/Results | <input type="checkbox"/> Medications | <input type="checkbox"/> Any/All Information: |

Confidential information to be disclosed: (Please note this information will only be released if checked):

- | | |
|--|--|
| <input type="checkbox"/> Mental Health Information | <input type="checkbox"/> Alcohol/Drug Information |
| <input type="checkbox"/> HIV Information | <input type="checkbox"/> Genetic Testing Information |

Purpose(s) for this authorization is (check all that applies):

- At the Request of the Individual Other: _____

Recipient(s) of information:

Name	Date of Birth	Relationship	Phone Number

This authorization will remain in effect one year from date signed or:

- Five (5) years from date signed

I acknowledge and understand that:

- This authorization is giving Ada West Dermatology the right to disclose my medical information to the individual(s) listed above.
- I have the right to revoke this authorization at any time by providing written notice to Ada West Dermatology, except to the extent that action has already been taken based on this authorization.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA Privacy Regulations.
- This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.
- If PHI (Protected Health Information) is sold or used in marketing involving financial remuneration, the remuneration will be to the covered entity.

Signature of Patient or Representative: _____ **Date:** _____

Representative Name (printed): _____ **Authority:** _____

(If signed by the patient's Personal Representative, please print name and describe authority to act for the individual.)