SKIN PROFESSIONALS WEST

Patient Information

Please present picture ID and Insurance Card

Name:

First Middle Last Preferred Name

Date of Birth:____/____/_____Age:_____Gender: ☐Female ☐Male Marital Status: ☐S ☐M ☐D ☐W

Address:

Street City State Zip

Cell: ( ) - Home: ( ) - Work: ( ) - Ext:

Email: Race: ☐ W ☐ B ☐ Latino ☐Other:

Employer: Occupation:

Emergency Contact: Phone: Relationship:

Preferred Pharmacy: Address:

Primary Care Doctor: Fax: Phone:

Doctor who referred you: Fax: Phone:

How did you hear about us:

☐ Doctor Referral ☐ Google ☐ Billboard ☐ Word of Mouth ☐ Print Ad (specify: _____) ☐Other: _____

Insurance Policy Holder: ☐ Check if same as person above

First Name: M.I.: Last Name:

Date of Birth: / / Social Security #: - - Relationship to Patient:

Address:

Street City State Zip

Cell phone: ( ) - Home Phone: ( ) - Work Phone: ( ) - Ext.:

Insurance Information (Please present card at time of check-in):

Primary Insurance Name:		Group #	ID#
Policy Holder Name:	Date of Birth:	SS #	Relationship to Patient:
Secondary Insurance Name:		Group #	ID#
Policy Holder Name:	Date of Birth:	SS #	Relationship to Patient:

Patient or Guardian Signature: _____ Date: _____

SKIN PROFESSIONALS WEST

General Consent Form

CONSENT FOR TREATMENT: By signing this form, I consent and authorize my health care provider to examine and treat me. I understand that this could include lab tests, procedures such as biopsies and destructions, other diagnostic tests. These services could be billed separately by different laboratory and pathology companies. I understand that my provider is available to explain the purpose of the treatment, tests and procedures and that I have the right to refuse his/her recommendations.

BILLING AUTHORIZATION: I hereby authorize SKIN PROFESSIONALS WEST to release requested medical information to my insurance company to collect payment for any charges.

ASSIGNMENT OF BENEFITS: I hereby request that payment of insurance benefits be made directly to SKIN PROFESSIONALS WEST on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to services for myself or my dependent. It is my responsibility to know my insurance policy and benefits coverage. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay any balances promptly.

MEDICARE AUTHORIZATION: I request the payment of authorized Medicare benefits be made on my behalf to SKIN PROFESSIONALS WEST for any services furnished to me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that Medicare may deem certain services as non-covered. Should I choose to receive those services, after being so informed, I assume responsibility for payment of those services rendered.

FINANCIAL POLICY: I hereby acknowledge that I had access to a copy of the financial policy of SKIN PROFESSIONALS WEST and have been able to review the policy. I know that any co-pay is due at the time of service. I am familiar with SKIN PROFESSIONALS WEST policies on insurance benefits, claims, referrals, precertification, and lack of insurance. I am also aware of SKIN PROFESSIONALS WEST policies on finance charges and past due balances as well.

PATIENT'S RIGHT TO PRIVACY: I acknowledge I have been made aware of Skin Professionals West HIPAA Privacy Practices that pertain to my rights regarding the use and disclosure of my protected health information. These rights are more fully described in this office's Notice of Privacy Practices. I understand a copy of Skin Professionals West Privacy Practices is available to me on the practice website or in the office upon my request. I consent to be contacted by Skin Prfessionals West or other business associates at the physical address, phone numbers and emails provided.

BLOOD TESTING: I understand that while receiving care, a healthcare worker may accidently be exposed to my blood or other bodily fluid. If this rare event occurs, I consent to my blood be tested for the presence of infectious diseases to protect the health care worker.

ELECTRONIC PRESCRIBING: I authorize SKIN PROFESSIONALS WEST to retrieve my medication history from my pharmacy through their e-prescribing system and then import my current medications into my electronic medical record.

PHOTOGRAPHY: I consent to mt pictures being taken for medical records, communication with other health care providers involved in my care, publications and marketing materials without revealing my identity.

AUTHORIZATION TO LEAVE DETAILED PHONE MESSAGES: I authorize staff of Skin Professionals West to call or leave **detailed messages** with information about my health, billing, financials and prescriptions at the following phone numbers:

Home: Cell: Work:

AUTHORIZATION TO COMMUNICATE: I authorize Skin Professionals West to communicate with me via □ phone □ text □ email

Home: Cell: Email:

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION: I authorize Skin Professionals West to discuss **ALL ASPECTS** of my protected health information including but not limited to tests results, billing, financials and prescription information with the following individuals:

Name: Relationship: Phone:

Name: Relationship: Phone:

PRINT Name of patient: **Date of Birth**:

PRINT Name of guardian or legal representative signing for patient:

Signature: **Date:**

SKIN PROFESSIONALS WEST

Medical Treatment Authorization for a Minor

Patient Name:_____ Date of Birth:_____

This consent will authorize Skin Professionals West to provide medical care for the minor child listed above without my physical presence.

I understand that I may revoke this request at any time.
This consent will automatically expire 1 year from the signed date.

Name and signature of parent or guardian: _____

Relationship to above patient: _____

Date consent obtained (verbal or written): _____

Written Consent obtained by (requires the signature of one witness):

Name and signature of witness: _____

Date written consent obtained: _____

Verbal Consent obtained over the phone, must be given to two staff members of Skin Professionals West. The following two employees received verbal consent from guardian to treat the above minor.

1st Employee's name and signature: _____

2nd employee's name and signature: _____

Date verbal consent obtained: _____

Reason patient is unable to consent for themselves: Patient is under the age of 18 and is considered a minor.

This Medical Consent will expire on: _____
(1 year from the date listed above)

SKIN PROFESSIONALS WEST

HIPAA Patient Confidentiality Form
For Visitors, Students, Consultants and Business Associates

Visitors, students, consultants and business associates to Skin Professionals West where patients are treated must sign this confidentiality agreement in compliance with HIPAA Privacy Law. You acknowledge with your signature you will protect personal health information of patients from being disclosed. You will not record, copy, release and disseminate protected patient health information you encounter at Skin Professionals West. You will keep all patient health information in confidence.

You acknowledge under Health Information Portability and Accountability Act (HIPAA) individually identifiable health information may be disclosed only with written permission of the patient. All discussions about patient medical conditions must be kept in a private setting. All medical records are to be accessed on an as needed basis.

By signing below you indicate you have read and agree to above policy.

Name _____ Date _____

Signature _____

KD 08/15/2021

SKIN PROFESSIONALS WEST

Secure Credit Card on File Policy

Skin Professionals West requires patients to keep a credit or debit card on file to pay any balance due after insurance has made payment to us (includes both primary and secondary insurance companies) and for self-pay patients. This card will be used only to charge the balance due on the patient's account (co-payments, co-insurance amounts, deductibles, no-show fee, returned check fee, interest charge for overdue payments, payment plan installments and other fees listed in our Financial Policy and General Consent). **We will send you one invoice and await payment. If no payment is received within 20 days after the date of the invoice, we will charge your card on file the outstanding balance due.**

If you do not have a credit or debit card, we will need a check for $100 written out to Skin Professionals West to be kept on file.

Itemized receipts will be sent to you for any charges made to your credit or debit card.

We do not physically store your credit card information on paper or on our computers. Your credit or debit card information is kept on file securely with Modernizing Medicine, our secure, cloud-based third-party HIPAA and PCI compliant electronic practice management software provider.

Please provide your credit or debit card to the front desk staff to enter in your electronic chart.

Thank you

By signing this form, I authorize Skin Professionals West to charge co-pays and any outstanding balances on my account to the credit card, debit card or check kept on file.

_____ _____

Patient Signature Date

_____ _____

Patient Name (Printed) Witness

*For patients with financial hardship or other extenuating circumstances a payment plan can be worked out with the office.

SKIN PROFESSIONALS WEST

Medical Records Release/Request Authorization

I, _____, authorize Skin Professionals West to

REQUEST AND RELEASE my medical records to and from the following health care providers and health care facilities that are involved in my care:

NAME OF PROVIDER / HEALTH CARE FACILITY: _____

These records include, but are not limited to the following:

❑ **Test Results** ❑ **Visit and Operative Notes** ❑ **Images**

❑ **Pathology Slides** ❑ **Medication lists**

Patient Name: _____ Date of Birth:_____

Address:_____

Phone Number:_____

_____

Signature of Authorization of Patient/Guardian Date

Skin Professionals West
582 Cherry Dr.
Waconia, MN 55387
P: 952-395-6850 Fax: 952-395-6870

www.skinpw.com