*Kirkland Dermatology Associates*

**Please complete all forms and return to the Front Desk.**

**Full Name:** _____ **DOB:** _____ Preferred Name: _____
*First* *MI* *Last*

Birth Sex: ☐ M ☐ F ☐Unknown Preferred Pronoun: ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Their

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman
☐ Genderqueer (neither exclusively male nor female ☐ Other ☐ Choose not to disclose

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: _____

Preferred Language: ☐ Decline to specify ☐ English ☐ Spanish ☐ Other: _____

Ethnic Group: ☐ Decline to specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ Decline to specify ☐ White ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American ☐ Other

Emergency Contact/Full Name: _____ Phone: _____

**Home Phone:** _____ **Work Phone:** _____ **Mobile Phone:** _____

**Preferred Phone:** ☐ Home ☐ Work ☐ Mobile **Is it okay to leave detailed messages?** ☐ YES ☐ NO

**Email Address:** _____

**Mailing Address:** _____
*Street* *City* *State* *Zip*

**Employer:** _____ **Occupation:** _____

**Release of my Protected Health Information: ☐ Decline**
I give permission to the following person(s) to speak with anyone from Kirkland Dermatology Associates, PLLC about my confidential health, billing, and/or any other relevant information.
Name: _____ Phone: _____ Relation to Patient: _____
*(Any authorizations given will automatically expire after 3 years from date of signature)*

**Insurance Policy Holder (*if different from patient*):** Patient relationship to subscriber: (Circle one): Spouse Child Other
Primary Insurance Policy Holder Name: _____ DOB: _____

Secondary Insurance Policy Holder Name: _____ DOB: _____

**Preferred Pharmacy Name:** _____
*Address or street*
Phone#: _____ City or Zip code: _____

**Primary Care Doctor:** _____
*Full name* *Location*
**Referring Doctor (if applicable):** _____
*Full name* *Location*

***Please see next page for Policies and Signature--->***

**Insurance Information:**

I authorize any holder of medical or other information about me to release to the insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

**Payment Policy:**

**Medicare, HMO, PPO, or Other managed care patients:** You will be responsible for paying your annual deductible, copayment, and charges for any non-covered, cosmetic services at the time of service (such as, but not limited to, hair loss diagnosis and treatment, destruction of benign lesions, including seborrheic keratosis, skin tag removal, milia removal, etc. and treatment of some pigment disorders).

**Patient Financial Responsibilities**

Kirkland Dermatology Associates is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful.

**You can help ensure an efficient experience by assisting with the following:**

- Providing us with your picture identification and insurance cards
- Knowing your insurance benefits and limitations
- Obtaining authorization for your visit if it is required by your insurance, including obtaining a referral.
- Providing us with at least 24 hours' notice should you need to cancel or reschedule an appointment.

**Patient Responsibilities**

- You are responsible for payment of services you receive in our office. Please understand that your medical insurance is a contract between you and your insurance company. **You are responsible for any unpaid balance, copays, co-insurance, and deductible**.
- We will gladly bill your insurance company with the appropriate charges and diagnosis codes. If your insurance carrier does not pay for the services, please do not ask us to change codes. We follow strict coding guidelines by the American Medical Association as well as those established and covered by federal and state programs.
- Your copay is due at the time of your visit.
- Without insurance coverage, you will be considered self-pay and your balance will be collected in full at the time of service.

**Insured Patients-** We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance with us, you must notify our business office and make payment arrangements. If your insurance has not paid within 45 days of the date of service, you will be responsible for the payment of the bill to the clinic, and will be reimbursed once your insurance pays your bill.

- **Co-Pays/Deductibles/Co-Insurance** – Please be prepared to pay for your portion of the charges on the date of service. Office procedures (e.g., tests, labs, etc.) will be billed separately from the office visit.
- **Non-Participating Insurance** – If we do not participate with your insurance, you will be required to pay for your visit in full on the date of service. We will file a claim with your insurance as a courtesy. If your insurance pays a portion of the claim we submit, we will refund you the amount they paid.
- **No Show/Late Cancel-**We may charge a $75 fee for missed appointments, and those cancelled with less than 24 hours' notice.

**Uninsured Patients-**

- **Office Visits** – We ask that you pay the full amount of your visit on the date of services. Office procedures (e.g., labs, tests, etc.) will be billed separately from the office visit.
- **Other Charges- No Show** – Please provide us with at least 24 hours' notice if you need to cancel or reschedule an appointment. We may charge a $75 fee for missed appointments.
- **Payment Options** – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third-party checks). We charge a $40.00 NSF fee for any returned checks.
- **Delinquent Accounts** –We may assign an account to collections if balances are unpaid after 90 days. Patients assigned to collections may be denied additional service.
- **Bankruptcy/ Bad Debt/Collections** – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Kirkland Dermatology Associates will be required to pay for any bad debt/collection balance. You will be required to pay a minimum deposit of $300 prior to service, which will be held until payment is received from insurance.

**Receipt of Notice of Privacy Practices and Financial Policy:**

My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices) and the Financial Policy.

**Patient or Responsible Party Signature: _____Date_____/_____/_____**

**Patient Name:** _____ **DOB:** _____

## History and Intake Form

**Past Medical History:** *(please circle all that apply)* ☐ **NONE**

| | | |
|---|---|---|
| Acute hepatitis | Diabetes mellitis | Malignant: |
| Anxiety disorder | Disease caused by Covid 19 | ☐ Lymphoma |
| Arthritis | Elevated blood pressure | ☐ Tumor of lung |
| Asthma | End stage kidney disease | ☐ Tumor of breast |
| Benign prostatic hyperplasia | Hearing loss | ☐ Tumor of colon |
| Cancer; Type: _____ | HIV infection | ☐ Tumor of prostate |
| Chronic obstructive lung disease | High cholesterol | Radiation therapy |
| Coronary heart disease | History of thyroid disorder | Stroke |
| Depressive disorder | Leukemia | Other:_____ |
| | | _____ |

**Past Surgical History:** *(please circle all that apply)* ☐ **NONE**

Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
Heart: Valve replacement
Hysterectomy
Surgical biopsy of skin
Transplant; ☐ Bone marrow ☐ Heart ☐Liver
Joint replacement; ☐Hip R/L Both ☐Knee R/L Both
Vasectomy
Other:_____

**Skin Disease History:** *(please circle all that apply)* ☐ **NONE**

| | | |
|---|---|---|
| Acne | Contact derm due to poison ivy | Malignant melanoma |
| Actinic keratosis | Eczema | Psoriasis |
| Asthma | History of hay fever | Squamous cell cancer |
| Basal cell skin cancer | History of atypical nevus | Sunburn (2nd degree) |
| Complaining of dry skin | Itchy scalp | |

Other _____

Do you wear sunscreen? ☐ Yes ☐ NO If yes, what SPF? _____
Do you tan in a tanning salon? ☐ Yes ☐ No
Do you have a **family** history of Melanoma? ☐ Yes ☐ No
*If yes, which relative(s)?* _____

**Current Medications:** ☐ **NONE**
*(Please enter all current medications-include dosages and supplement names)*

_____
_____
_____
_____

***Please see next page --->***

**Drug Allergies**: *(Please enter all allergies and **reactions**)* ☐ **NONE**

_____

_____

**What is your smoking status:** ☐ Unknown ☐ Never smoker ☐ Current everyday smoker
☐ Current some day smoker (cigar) ☐ Current some day smoker (cigarette)
☐ Former smoker ☐ Cigar smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker

How many times in the past year have you had 5 or more drinks in a day for men,
or 4 or more drinks in a day for women or any adult older than 65?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9

**Do you consume alcohol?**
☐ None ☐Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

**ALERTS:** *(Please circle all that apply)*

☐ **NONE**

Are you pregnant or currently trying to get pregnant?

Allergy to Adhesive

Allergy to Lidocaine

Allergy to topical Antibiotics

Allergy to Latex

Artificial Heart Valve

Artificial Joint within the past 2 years

Blood Thinners

Defibrillator

MRSA

Pacemaker

Require Antibiotics prior to a surgical procedure.

Rapid heartbeat with Epinephrine

HIV/ Hepatitis B or C

Personal History of Melanoma