Dermatology and Laser Institute of Colorado, P.C.
9695 S. Yosemite Street, Suite 175
Lone Tree CO 80124

INSTRUCTIONS FOR PAPERWORK

Welcome to **Dermatology and Laser Institute of Colorado** and **nV DermSpa**! And welcome to an innovative, yet traditional approach to practicing medicine! Whether you are a new or long-time patient, we are thrilled that you have entrusted your care to us. We plan to **exceed** your expectations!

We are a **direct pay practice** which means that we do not participate with any insurance or government healthcare program, including Medicare, Medicaid, and ANY commercial insurance plan. Patients pay a reasonable fee for their care at the time of service. We do not work for insurance companies or the government. **We work for you.**

Please note that we now offer **telemedicine** or video visits for select skin conditions! Patients can see Dr. Ort virtually from the comfort and safety of their homes.

Our streamlined registration process eliminates the need for insurance cards, prior authorizations, and referrals. The following are the forms that you will be asked to complete. Thank you.

1. REGISTRATION (2 pages)

2. FINANCIAL and HIPAA POLICY (2 pages)

3. MEDICARE and MEDICAID FORM (1 page)

4. MEDICAL HISTORY (1 page)

Please note: For HIPAA and patient identification purposes, we will request a photo ID to be scanned and stored according to our Privacy Policy.

About Your Doctor

Dr. Richard J. Ort, M.D., Director of the Dermatology and Laser Institute of Colorado, is a Board-Certified Dermatologist who founded the practice in 2001. Dr. Ort has extensive training in medical and surgical dermatology, as well as lasers and injectables such as botulinum toxin and fillers.

Highlights of Dr. Ort's training include:

- **Princeton University** Undergraduate Degree
- **Columbia University** Medical Degree
- **University of Pennsylvania** Internship in Internal Medicine
- **Emory University** Residency in Dermatology
- **Harvard University** Fellowship in Laser, Cosmetic, and Skin Cancer Surgery

· 20+ years experience in medical and cosmetic dermatology
· Recognized expert in laser surgery with 10 state-of-the-art lasers in the practice
· 15+ years as volunteer faculty member teaching surgery at the Denver VA Medical Center
· 20+ years providing dermatology instruction to medical students and residents
· Broad experience as an expert in medical malpractice and peer review cases

© Copyright 2001-2020, Dermatology & Laser Institute of Colorado / Richard J Ort MD, All Rights Reserved

Dermatology and Laser Institute of Colorado, P.C.
9695 S. Yosemite Street, Suite 175
Lone Tree CO 80124

REGISTRATION (PAGE 1)

Today's Date _____/_____/_____

Name ____
(Last) (First) (Middle Initial)

Mailing Address____
(Street)

____
(City) (State) (Zip)

Home Phone (______)___________________ Date of Birth _____/_____/_____ Age _______

Cell Phone (______)___________________ Social Security Number ______________________

Sex M / F Marital Status S / M / D / W
(Circle One)

FINANCIALLY RESPONSIBLE PARTY

□ Same as patient □ Other than patient, relationship ______________________________

Name ____
(Last) (First) (Middle Initial)

Mailing Address____
(Street) (City) (State) (Zip)

Home Phone (______)___________________ Cell Phone (______)___________________

EMERGENCY CONTACT

In case of an emergency, who may we contact?

Name __________________________ Relationship ______________ Phone (_____)_____________

Mailing Address____
(Street) (City) (State) (Zip)

REFERRAL AND PHYSICIAN INFORMATION

How did you hear about us? □ Website □ Online Search □ RealSelf □ Yelp □ Mailer □ Printed Ad

□ Patient Referral (Name) ___________________ □ Doctor Referral (Name) ___________________

□ Other ____

Your Primary Care Physician____________________________________ Phone________________

Other family members that are patients____

© Copyright 2001-2020, Dermatology & Laser Institute of Colorado / Richard J Ort MD, All Rights Reserved

Dermatology and Laser Institute of Colorado, P.C.
9695 S. Yosemite Street, Suite 175
Lone Tree CO 80124

REGISTRATION (PAGE 2)

Patient Name: ____

PREFERRED PHARMACY

Pharmacy Name______________________________________ Phone______________________

Location or Cross Streets____

Please instruct your pharmacy to fax all prescription refill requests to us first, before you call the office. We will strive to complete any refill requests within 2 business days of the request.

APPOINTMENT CONFIRMATIONS

Our office will text or email you with appointment reminders. Please provide the following:

Phone (______)_________________ Email __________________________@_________________

I would like to receive promotions or other information from the practice via email: □ Yes □ No

CONFIDENTIAL COMMUNICATION

Email: To protect your privacy, we do not use email to communicate with you regarding Protected Health Information (PHI). If you wish to communicate with us via email, we will provide instructions on how to send end-to-end encrypted email. Please do not send any email without speaking to us first. If you send an email which is not end-to-end encrypted, you assume all security and privacy risks.

Lab Tests: You may require a skin biopsy or other lab test. Results are typically available in one week or less. Do not assume that results are negative if you have not heard from the office. Please call our office if you have not received your results within two weeks of the biopsy or test.

Please fill in as appropriate:

I authorize to be notified of medical results at this phone number: (______)__________________

I authorize messages with medical results to be left at this number: (______)__________________

I authorize messages with medical results to be left with certain individuals at these phone numbers:

Name _________________________ Relationship _______________ (______)__________________

Name _________________________ Relationship _______________ (______)__________________

By signing this form, you consent to allow our office to communicate with you by the means designated above. This consent will remain in effect unless revoked by you.

x____ _______/_______/________

Patient or Guardian Signature **Date**

© Copyright 2001-2020, Dermatology & Laser Institute of Colorado / Richard J Ort MD, All Rights Reserved

Dermatology and Laser Institute of Colorado, P.C.
9695 S. Yosemite Street, Suite 175
Lone Tree CO 80124

FINANCIAL POLICY (PAGE 1)

Patient Name: ____

1. **Direct Pay Practice.** We are a direct pay practice and do NOT participate with ANY commercial insurance or government healthcare plan. This includes Medicare, Medicaid, Medigap, and Tricare. Dr. Ort is considered an OUT OF NETWORK provider for ALL insurance plans.

2. **Payment.** Payment in full is required for all services before you leave our office. We accept cash, check, credit cards, and debit cards, including HSA cards for qualified services. A deposit or prepayment may be required prior to scheduling some procedures.

3. **Pricing.** The fee for your visit is based on time spent with Dr. Ort. There are three different pricing levels depending on procedures performed. Our fees are posted on our website.

4. **Telemedicine.** The fee for a telemedicine or video visit is the same as for a regular visit.

5. **Cosmetic.** Cosmetic services are billed under a separate fee schedule.

6. **Out of Network.** Insurance companies may reimburse you under out-of-network coverage, depending on your specific benefits. If you would like to file for reimbursement, for a nominal fee we will provide a form with the relevant CPT and ICD-10 codes that you can submit to your insurance carrier. Please note that it is your responsibility to understand your plan's out of network coverage. We do not make any representation that your claim will be reimbursed partially or in full. If you have questions, please contact your insurance company or benefits manager.

7. **Medicare.** All Medicare patients must sign a one-page private contract with Dr. Ort acknowledging that medical services will not be covered and that a claim will not be submitted to Medicare. This applies both to traditional Medicare as well as Medicare Advantage plans. Please note that any prescriptions or tests from Dr. Ort will still be covered by Medicare.

8. **Medicaid.** Under Colorado law, Medicaid patients cannot be billed for any medical service covered by Medicaid, even if the patient agrees in advance to self-pay for the care. We can treat Medicaid patients only for cosmetic services that are not covered by Medicaid.

9. **FSA/HSA.** Flexible Spending Accounts (FSA) or Health Savings Accounts (HSA) can be used to pay for non-cosmetic services.

10. **Labs.** If you need any biopsy tests or lab work, you will receive a separate bill from the lab. If you have insurance, you may choose to have these services billed to your insurance. We have negotiated discounted lab fees for our self-pay patients.

11. **Prior Authorizations.** There is a $25 charge to complete a medication prior authorization.

12. **Forms.** There is a $25 charge to complete FMLA forms, cancer policy forms, etc.

13. **Skin Care Products.** All product sales are final. No refunds will be issued.

14. **Legal.** Any legal documents for Guardianship or Power of Attorney must be presented at the time of service. All legal documents must be original copies.

15. **Children.** All children under 18 years of age must be accompanied by a parent or legal guardian on the first visit as per Colorado law. The parent or legal guardian must sign an authorization form if the child is to be seen alone during routine follow-up visits.

© Copyright 2001-2020, Dermatology & Laser Institute of Colorado / Richard J Ort MD, All Rights Reserved

Dermatology and Laser Institute of Colorado, P.C.
9695 S. Yosemite Street, Suite 175
Lone Tree CO 80124

FINANCIAL POLICY (PAGE 2)

Patient Name: ____

16. **Cancellations.** Your appointment time is reserved exclusively for you. If you need to cancel an appointment, please provide at least two full business days notice. If you are scheduled for a procedure and fail to provide the above notice, or if you "no-show", you will be assessed a minimum cancellation fee of $100.00. You will be unable to schedule any new appointments until the fee is paid.

17. **Fees.** There is a $50.00 fee for any check returned by our bank or for any credit card transaction that is returned by our merchant banker. There is a $50.00 fee if your account is sent to a collections agency.

Your signature below signifies that you have read and understand this financial policy.

I attest that I have read and understand the above information and that any questions have been explained to my satisfaction. I agree to comply with the terms of this financial policy and to pay in full for all services rendered at the time of my visit.

x____ _______/_______/________
Patient or Guardian Signature **Date**

HIPAA POLICY

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). We are required by law to maintain the confidentiality of this PHI under the Heath Insurance Portability and Accountability Act (HIPAA). We cannot release or discuss PHI with spouses, parents of dependents who are 18 or older, or parents acting as caretakers for disabled or aged adults unless express legal documentation has been provided. Patients who would like us to discuss or disclose PHI to a designated family member, friend, or caretaker must sign a release form permitting such disclosure.

Your signature below signifies that you have been notified and offered a copy of our Notice of Privacy Practices.

x____ _______/_______/________
Patient or Guardian Signature **Date**

© Copyright 2001-2020, Dermatology & Laser Institute of Colorado / Richard J Ort MD, All Rights Reserved

Dermatology and Laser Institute of Colorado, P.C.
9695 S. Yosemite Street, Suite 175
Lone Tree CO 80124

MEDICARE & MEDICAID

Patient Name: ____

Please answer Questions 1 and 2 and sign below.

1. Do you have MEDICARE?

All patients must initial on ONE of the following lines.

I hereby attest to the following:

___________ **INITIAL** I (or my dependent) **AM NOT** currently enrolled in Medicare, including Original Medicare, a Medicare Advantage Plan, or any other Medicare plan, whether as a primary, secondary, or tertiary plan.

or

___________ **INTIAL** I (or my dependent) **AM** enrolled in Medicare or a Medicare plan, whether as a primary, secondary, or tertiary plan. I understand that Dr. Ort has opted out of Medicare. I understand that Medicare rules require that I sign a one-page private contract with Dr. Ort indicating that medical services will not be covered by Medicare.

2. Do you have MEDICAID?

All patients must initial on ONE of the following lines.

I hereby attest to the following:

___________ **INITIAL** I (or my dependent) **AM NOT** currently enrolled in Medicaid or any Medicaid plan, whether as a primary, secondary, or tertiary plan.

or

___________ **INITIAL** I (or my dependent) **AM** currently enrolled in Medicaid or a Medicaid plan, whether as a primary, secondary, or tertiary plan. I understand that, due to Colorado law, this office does not treat Medicaid patients for any care which is considered medically necessary. I am seeking purely **COSMETIC** services which are not medically necessary.

x____ ________/_______/________
Patient or Guardian Signature **Date**

© Copyright 2001-2020, Dermatology & Laser Institute of Colorado / Richard J Ort MD, All Rights Reserved

Dermatology and Laser Institute of Colorado, P.C.
9695 S Yosemite St, Ste 175
Lone Tree CO 80124

MEDICAL HISTORY

Patient: ______________________ D.O.B.: ______________ Date: ______________

What is the primary reason for your visit? ______________________

Please list all medications that you are currently taking: ______________________

____

____

Are you allergic to any medications? ☐ **Yes** ☐ **No** ***This is important;*** if Yes, please list on the line below:

____

Do you now have, or have you ever had, diseases or conditions of:

Lungs	Yes	No	Other	Yes	No		Yes	No
Emphysema	☐	☐	Excessive Bleeding	☐	☐	Cold Sores	☐	☐
Asthma	☐	☐	Excessive Clotting	☐	☐	Keloids	☐	☐
Pulmonary Embolus	☐	☐	Diabetes	☐	☐	Abnormal Healing	☐	☐
On Supplemental Oxygen	☐	☐	Thyroid	☐	☐	Cancer	☐	☐
Cardiovascular	**Yes**	**No**	Kidney	☐	☐	"type" ______		
High Blood Pressure	☐	☐	Bladder	☐	☐	Radiation Treatment	☐	☐
Chest Pain	☐	☐	Stomach or Bowel	☐	☐	Depression	☐	☐
Heart Attack	☐	☐	Liver or Hepatitis	☐	☐	Psychiatric Problem	☐	☐
Artificial Valves	☐	☐	Artificial Joints	☐	☐	Do You Smoke	☐	☐
Heart Murmurs	☐	☐	Arthritis	☐	☐	Drink Excess Alcohol	☐	☐
Mitral Valve Prolapse	☐	☐	HIV / AIDS	☐	☐	Do You Use Drugs	☐	☐
Rheumatic Fever	☐	☐	Stroke	☐	☐	Do You Sunbathe	☐	☐
Atrial Fibrillation	☐	☐	Seizures / Epilepsy	☐	☐	Use Tanning Beds	☐	☐
Pacemaker	☐	☐	Fainting	☐	☐	Use Sun Screen	☐	☐
Internal Defibrillator	☐	☐	Auto-Immune Disease	☐	☐	**Females –** (Only)	**Yes**	**No**
Irregular Heart Beat	☐	☐	Ever Taken Accutane®	☐	☐	Pregnant	☐	☐
						Trying To Get Pregnant	☐	☐

Please list any other disease or condition: ______________________

Skin: Have you ever had skin cancer? ☐ Yes ☐ No If Yes, please list type and location (if known)
(For example, TYPE for skin cancers are: basal cell cancer, squamous cell cancer, malignant melanoma)

Type: ______________________ Location: ______________________

Has anyone in your family had skin cancer? ☐ Yes ☐ No If Yes, please list type and location (if known)
Type: ______________________ Location: ______________________

Do you have a history of specific skin diseases? ☐ Yes ☐ No If Yes, please list details

____

On a scale of 1 to 10 how would you rate the appearance of your skin? (circle one) 1 2 3 4 5 6 7 8 9 10
Need Help **Average** **Very Good**

What is your occupation? ______________________
What are your hobbies? ______________________

Are you interested in learning more about our Cosmetic Services and / or nV Skin Care products? ☐ Yes ☐ No

______________________ ______________________
Reviewed and signed by provider Date

Information above corrected and re-reviewed

Provider Initial/Date	Provider Initial/Date	Provider Initial/Date	Provider Initial/Date	Provider Initial/Date	Provider Initial/Date

© Copyright, 2009-2020, Dermatology & Laser Institute of Colorado, Richard J. Ort, M.D., All Rights Reserved