

INSTRUCTIONS FOR PAPERWORK

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

As of October 1, 2015, 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 our patients.**

We hope that you will enjoy our streamlined registration process that eliminates the need for insurance cards, prior authorizations, and referrals. The following are the forms that you will be asked to complete for your first visit and annually thereafter. In order to avoid any delays during your office visit, please print and fill out the forms ahead of time and bring them with you. 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's extensive training in medical and surgical dermatology as well as lasers and cosmetic surgery enables him to meet the complete skin care needs of his patients.

Highlights of Dr. Ort's training include:

- **Princeton University** Undergraduate Degree, Magna Cum Laude
 - **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
 - 10+ years as volunteer faculty member teaching surgery at the Denver VA Medical Center
 - 10+ years providing dermatology instruction to medical students and residents
 - Broad experience as an expert witness in medical malpractice cases

REGISTRATION (PAGE 1)

Today's Date ____/____/____

Name _____
(Last) (First) (Middle Initial)

Mailing Address _____
(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 _____
(City) (State) (Zip)

Home Phone (____) _____ Cell Phone (____) _____

EMERGENCY CONTACT

In case of an emergency, who may we contact?

Name _____ Relationship _____ Phone (____) _____

Mailing Address _____
(City) (State) (Zip)

REFERRAL AND PHYSICIAN INFORMATION

How did you hear about us? Website Online Search RealSelf.com Mailer Printed Ad

Patient Referral (Name) _____ Doctor Referral (Name) _____

Other _____

Your Primary Care Physician _____ Phone _____

Other family members that are patients _____

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 into the office. We will strive to complete any refill requests within 2 business days of the request.

APPOINTMENT CONFIRMATIONS

As a courtesy, our office will call you with an appointment reminder. Please provide a preferred phone number. If you would like to use email for this purpose, please provide your email address.

Phone (_____) _____ Email _____ @ _____

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

To protect your privacy, we do not use email to communicate with you regarding any private medical information. Please do not send any private medical information via email to our office.

CONFIDENTIAL COMMUNICATION

You may require a skin biopsy or other lab work to be done. Results are typically available in one week or less. You should not assume that results are negative if you have not heard from the office. You should contact our office if you have not received your results within two weeks of the procedure.

Please read the following and 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. You may be required to update this consent on an ongoing basis or if you would like to change the above information.

x _____
Patient or Guardian Signature

_____/_____/_____
Date

FINANCIAL & HIPAA POLICY (PAGE 1)

Patient Name: _____

NOTE: You must read and sign both policies (two pages), prior to receiving care at our office.

1. **Direct Pay Practice** We are a direct pay practice and do NOT participate with ANY insurance or government healthcare program. Patients pay for their care at the time of service.
2. **Payment** Payment in full is required for all services before you leave our office. Our office will accept Cash, Check, Visa, MasterCard, or Discover. A deposit or prepayment in full may be required prior to scheduling some procedures.
3. **Fees** The fee for your visit is based on 5-minute increments of time spent with Dr. Ort. There are three different pricing levels depending on which specific procedure is performed. Our transparent fees are posted on our website and available in our office. Please note that our fees are much lower than in offices that accept insurance.
4. **Cosmetic Services** Cosmetic services are billed under a separate and distinct fee schedule. As always, payment is due at the time of service.
5. **Out of Network** Dr. Ort is considered an OUT OF NETWORK provider for ALL insurance plans. Dr. Ort and the practice are not contracted with any government or commercial insurance plan. This includes Medicare, Medicaid, Medigap, Tricare, and all commercial primary, secondary and/or tertiary insurance plans.
6. **Out of Network Coverage** Insurance companies may reimburse you under out-of-network coverage, depending on your specific insurance. If you would like to file for reimbursement, please let us know during your visit. We will have to look up the relevant CPT (procedure) and ICD-10 (diagnosis) codes. We will provide you with a form which you can submit to your insurance carrier. Since this represents extra work, there will be a small extra charge (currently \$5.00). This information will be mailed to you after your visit. Please note that it is your responsibility to understand your plan's out of network coverage. We do not make any promises regarding whether your insurance company will reimburse you. If you have questions, you should speak with your insurance company or benefits manager.
7. **FSA/HSA** Medical (not cosmetic) services provided to you at our office are eligible for payment via Flexible Spending Accounts (FSAs) or Health Savings Accounts (HSAs).
8. **Labs** If you need any biopsy tests or lab work done by an outside lab, you will receive a separate bill from that lab. If you have insurance, you may choose to have these services billed to your insurance. We have negotiated discounted pathology fees with preferred labs for our self-pay patients.
9. **Products Purchased** All sales of skin care or other products sold in our office are final. No refunds will be issued for returned products.
10. **Medicare** If you are enrolled in Medicare, Medicare requires that you sign a one-page private contract with Dr. Ort indicating that you have been informed that medical services will not be covered. This applies both to traditional Medicare as well as Medicare Advantage plans. Please note that any prescriptions or tests ordered by Dr. Ort will still be covered by Medicare.
11. **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. Unfortunately, this prevents us from providing medical care to Medicaid patients. We can treat Medicaid patients only for cosmetic services that are not covered by Medicaid.

FINANCIAL & HIPAA POLICY (PAGE 2)

Patient Name: _____

12. **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. If these documents cannot be provided, you will be asked to reschedule the appointment. This office is NOT a party to any divorce decree.
13. **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 subsequent visits. Payment in full is still required at the time of service.
14. **Appointment Cancellations** Our business days are Monday through Friday. Your appointment date and time are reserved exclusively for you. If you need to cancel an appointment, please provide us with advance notice of at least two full business days. If you or a dependent are scheduled for a procedure and fail to provide at least two business days notice of cancellation, or if you or a dependent fail to appear (no-show) for the procedure, you will be assessed a minimum cancellation fee of \$100.00. We will be unable to schedule any new appointments until the cancellation fee is paid.
15. **Fees** We will assess a \$50.00 bounced check fee for any check returned to our bank due to insufficient funds or for any other reason. We will assess a \$50.00 charge-back fee for any credit card transaction that is returned by our merchant banker. We will assess a \$50.00 collections fee if your account is sent to a collections agency. We reserve the right to discharge from the practice any patient who does not pay in full at the time of service.

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

By signing this form, I attest that I have read and understand the above information and that my 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 Health 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

MEDICARE & MEDICAID

Patient Name: _____

You must initial on ONE line under MEDICARE and on ONE line under MEDICAID. Please provide your signature at the bottom of the page.

1. Do you have MEDICARE?

All patients must initial on ONE of the following lines. Please do not initial on both lines.

I hereby attest to the following:

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

or

_____ I (or my dependent) **AM** enrolled in Medicare or a Medicare plan, whether as a primary,
INITIAL 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. Please do not initial on both lines.

I hereby attest to the following:

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

or

_____ I (or my dependent) **AM** currently enrolled in Medicaid or a Medicaid plan, whether as a
INITIAL 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

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:

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

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 physician or extender _____

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