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

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

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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_____

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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**

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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.

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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 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**

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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:

_____ **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. Please do not initial on both 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**

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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
Emphysema	☐	☐
Asthma	☐	☐
Pulmonary Embolus	☐	☐
On Supplemental Oxygen	☐	☐
Cardiovascular	**Yes**	**No**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Artificial Valves	☐	☐
Heart Murmurs	☐	☐
Mitral Valve Prolapse	☐	☐
Rheumatic Fever	☐	☐
Atrial Fibrillation	☐	☐
Pacemaker	☐	☐
Internal Defibrillator	☐	☐
Irregular Heart Beat	☐	☐

Other	Yes	No
Excessive Bleeding	☐	☐
Excessive Clotting	☐	☐
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Stomach or Bowel	☐	☐
Liver or Hepatitis	☐	☐
Artificial Joints	☐	☐
Arthritis	☐	☐
HIV / AIDS	☐	☐
Stroke	☐	☐
Seizures / Epilepsy	☐	☐
Fainting	☐	☐
Auto-Immune Disease	☐	☐
Ever Taken Accutane®	☐	☐

	Yes	No
Cold Sores	☐	☐
Keloids	☐	☐
Abnormal Healing	☐	☐
Cancer	☐	☐
"type" _____		
Radiation Treatment	☐	☐
Depression	☐	☐
Psychiatric Problem	☐	☐
Do You Smoke	☐	☐
Drink Excess Alcohol	☐	☐
Do You Use Drugs	☐	☐
Do You Suntan	☐	☐
Use Tanning Beds/Booths	☐	☐
Use Sun Screen Outdoors	☐	☐
Females – (Only)	**Yes**	**No**
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 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

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