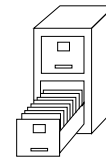


Today's Date \_\_\_\_\_

**PATIENT QUESTIONNAIRE**  
(for our records)  
Please Print  
Please answer ALL questions



Patient Information

Patient Name \_\_\_\_\_ Sex: M  F   
Address \_\_\_\_\_  
\_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_  
Marital Status \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Ext \_\_\_\_\_ Cell # \_\_\_\_\_  
Best place to reach you: Home  Work   
May we leave a message if we need to contact you? Yes  No   
SS# \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Other Family Members who are patients of Dr. Johnson? > Names \_\_\_\_\_

Financial Information

Person Financially Responsible \_\_\_\_\_ **Signature** \_\_\_\_\_  
Name of Primary Insured \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Name/Address/Phone # of Employer \_\_\_\_\_  
Medical Insurance Co. \_\_\_\_\_  
I.D. # \_\_\_\_\_ Group # \_\_\_\_\_  
Medicare # \_\_\_\_\_ Primary Insured D.O.B. \_\_\_\_\_  
SS # \_\_\_\_\_ Form of Payment: Cash  Check  MC/VISA  Insurance

Emergency

Who to Contact in case of an Emergency: Name \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
Address \_\_\_\_\_

Referral

Who referred you to Dr. Johnson? Doctor / Other Professional \_\_\_\_\_  
Family member/Friend(name) \_\_\_\_\_  
Sign  Phone Book  Internet  Other  \_\_\_\_\_

Medical History

Current Problem \_\_\_\_\_  
How Long? \_\_\_\_\_ Location \_\_\_\_\_  
Previous Treatments \_\_\_\_\_  
**ALLERGIES OR SENSITIVITIES?**  
Penicillin  Tetracycline  Sulfa  Codeine  Other Antibiotic/Med.  \_\_\_\_\_  
Novocaine or Local Anesthetic  Any Other Allergies \_\_\_\_\_  
**HAVE YOU EVER HAD?** High Blood Pressure  Diabetes  Ulcer  TB   
Psychiatric Disorder  Osteomyelitis  Glaucoma  Pacemaker   
Bleeding Disorder  Kidney disease  Heart or Heart Valve Disease   
Previous X-Ray Treatment  Previous Skin Cancer  Other Cancer or Tumors   
Details \_\_\_\_\_  
**DO YOU HAVE A FAMILY HISTORY OF:** Eczema  Hives  Allergies  Hay Fever   
Details \_\_\_\_\_  
Please list all Medications you are taking (incl. over-the-counter) \_\_\_\_\_  
\_\_\_\_\_ Birth Control Pills (females)?

# **REFERRAL, INSURANCE, LIABILITY, CANCELLATION, MUTUAL PRIVACY AGREEMENT AND PAYMENT POLICIES**

## **1. Patient Referral Waiver**

As a present or future member of a Health Maintenance Organization (HMO) or other third party payor, you recognize that you may be required by that HMO to receive a Primary Care Physician's (PCP) referral prior to being treated by Dr. Johnson, a specialist provider. You also recognize that it is your responsibility, not that of Dr. Johnson's office, to obtain the referral.

If you do not obtain a referral for the services provided by Dr. Johnson, you understand that you are circumventing my health care plan and thus the HMO may not be required to pay for services rendered. In such case, you agree to accept full financial responsibility for any direct or ancillary charges related to the services provided by Dr. Johnson outside of the scope of a referral.

If you do have a referral from your PCP to see Dr. Johnson and only certain services or procedures are authorized, you agree to accept full financial responsibility for any additional procedures that are deemed necessary, that you agree to by verbal consent and that are performed by Dr. Johnson or his staff.

## **2. Patient Insurance Release**

You hereby authorize the release of any medical or other information necessary to process this claim. You also hereby request payment of government benefits or other insurance benefits either to yourself or to the party who accepts assignment. If you are a Medicare patient, you hereby authorize payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is provided to the physician or supplier.

## **3. Waiver of Liability**

In some instances, insurance carriers deem certain procedures as not "medically necessary" or cosmetic thus they are not covered by insurance carriers. You hereby agree to accept full financial responsibility for medical services that are denied by insurance carriers for reason of not being medically necessary or cosmetic.

## **4. Cancellation and "No Show" Policy**

A \$30.00 charge will be assessed to your account if you fail to keep an appointment and do not call to cancel or reschedule within 24 hours of your scheduled appointment time. This will affect both new and established patients. After 3 consecutive no show appointments, patients will only be seen on a call-ahead, walk-in and space/time available basis only. While we reserve the right to make exceptions to this policy to accommodate extenuating circumstances, our appointment times are as valuable as your time. We strive to utilize our available appointments to effectively meet your needs.

## **5. Mutual Privacy Agreement**

Dr. Johnson and staff are committed to maintaining your absolute privacy above and beyond the requirements of HIPAA. By signing this agreement, you agree to refrain from directly or indirectly publishing or disseminating public remarks, commentary, ratings or reviews of Dr. Johnson's practice, treatment or expertise. Dr. Johnson provides you as a patient the same assurance. This mutual commitment includes disseminating information accessible via the Internet, professional or public review sites, blogs, Facebook, Twitter or their equivalents, and other similar electronic, print or broadcast media -- without the expressed prior written consent of the other party.

Dr. Johnson will utilize all legal rights of relief to prevent the initiation, continued publication or airing of such public commentary, and this agreement between you and Dr. Johnson will be in force and enforceable for a period of five years from your last date of service in his office.

## **6. Patient Payment Policy**

Office policy is that payment is to be made as services are rendered for self-pay patients, and after the first billing in instances where we file a claim with an insurance plan. If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our office manager. This will avoid misunderstandings and enable you to keep your account in good standing. Except when hardship warrants otherwise, accounts 120 days past due are referred to a collection agency. You would then be responsible for the costs of collection including reasonable attorney fees.

**I have read, I understand and I agreed to all of the above. All of my questions have been answered to my satisfaction.**

\_\_\_\_\_  
NAME OF PATIENT (Please print)

\_\_\_\_\_  
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE      \_\_\_\_\_  
DATE SIGNED

**RONALD A. JOHNSON, M.D.**

1665 Briargate Blvd., Colorado Springs, CO 80920 Telephone (719) 590-1800

**Health Insurance Portability and Accountability Act of 1996 (HIPAA) Consent Form**

Our Privacy Policy and Procedure Notice ("Notice") provides you with information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights Section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this consent form, you agree to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that:**

- Protected health information may be disclosed or used for treatment, payment or health care options
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke the consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

**This Consent was signed by:** \_\_\_\_\_

Print Name – Patient or Representative

\_\_\_\_\_  
Signature Date

Relationship to patient  
(if other than patient)

\_\_\_\_\_

Witness:

\_\_\_\_\_  
Signature Date

**RONALD A. JOHNSON, M.D.**

1665 Briargate Blvd., Suite 200  
Colorado Springs, CO 80920  
719-590-1800

## SWIPE YOUR CARD AND SAVE

To Our Patients:

As any of you who have checked into a hotel lately know, you are asked for a credit card at the time you check in. This is an advantage for both you and the hotel, since it makes checkout faster and more efficient. We have implemented a similar policy.

You will be asked for a credit card at the time you check in and the information will be held securely until your insurances have paid and made their determination of patient payable amounts, such as co-insurance, deductibles and co-pays. At that time any remaining balance owed by you will be charged to your credit card, and a copy of this will be mailed or faxed to you **at no charge**. Unless you direct otherwise, the credit card information will held securely and used for your account during the calendar year, after which, it must be updated and renewed.

**This will be an advantage to you in two ways, 1) you will no longer have to write out and mail us checks, and 2) you will save the monthly statement fee that accompanies our mailed account summaries.** It will be an advantage to us as it will greatly decrease the number of statements that we have to generate and send out. This will benefit everybody by helping to keep the costs of healthcare down.

For those who do not have access to a credit card, debit card or similar account, or for other reasons cannot participate in this valuable service, we will continue to provide mailed statements with the associated statement fee.

This in no way will compromise your ability to dispute a charge or an insurance company's determination of payment.

Co-pays due at the time of visit will continue to be payable at the time of visit.

Sincerely yours,  
Academy Dermatology and Laser Center  
Ronald Johnson, M.D.

I hereby authorize Academy Dermatology and Laser Center and Dr. Ronald Johnson to charge outstanding balances on my account to the following credit card:

Card: VISA / MC      Account Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Expiration Date: \_\_\_\_/\_\_\_\_ SID # (3 digit security code on back of card): \_\_\_\_\_

Name (as it appears on card): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

» Is this your Health Savings Account credit card?     Yes     No