

Medicare Patient Information

Name _____ SS#: _____

Birth Date _____ Age _____ Sex: Female Male

Home Address _____
Street _____
City _____ State _____ Zip Code _____

Home Phone () _____
Work Phone () _____

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does NOT apply to you, please check NO

Yes No

- Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
- Are you covered by a HMO/ PPO which makes Medicare secondary?
- Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
- Do you or your spouse work and have coverage through the insurance at your job?
- Are you eligible for any benefits under the Federal Black Lung Program?
- Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?
- Are you coming to this office due to Medicare disability coverage?
- Are you covered by the Federal End Stage Renal Disease Program?
- Are you presently receiving Workers' Compensation?
- Is the illness or injury you are coming to this office for the result of work-related causes?
- Do you have medical assistance through Welfare or state-aid?

If you answered YES to ANY of the above questions: _____
(Name of Company)

Policy Number _____ Group Number _____

Referring Physician: _____

-Continued on Back-

Name of Spouse or Close Relative or Friend _____

(In Case of Emergency)

Phone# () _____

Name As It Appears On Your Medicare Card

(Please Print)

Medicare Health Insurance Claim Number as it appears on your card

(This is usually your social security number. Be sure to include the letter after the nine digit number. It is important that we have both number and letter.)

Please Sign So We May Have Your Medicare Authorization On File:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare 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. Regulations pertaining to Medicare assignment of benefits apply.

Date _____ Signature _____

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare. (Medigap Coverage)

Name of Insurance Company _____

Policy Number _____ Group Number _____

Please Sign So We May Have Your Supplemental Authorization On File:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date _____ Signature _____



Crutchfield Dermatology

Look Good, Feel Great
with Beautiful Skin™

Dr. E. Crutchfield III, M.D.
Fellow, American Board of Dermatology
Fellow, American Academy of Dermatology
Associate Professor of Dermatology
at the University of Minnesota
Dermatology Clinic Medical School Graduate

General Dermatology

- Acne
- Psoriasis
- Skin Cancer
- Mole Exams
- Skin Exams
- Warts
- Rashes
- Pediatrics
- Skin Surgery
- Ethnic Skin
- Vitiligo

- Laser Surgery
- Acne
- Birthmarks (Port Wine)
- Warts
- Unwanted Hair
- Facial Veins
- Sun Damaged Skin
- Age Spots
- Wrinkles
- Pixel Laser for Acne Scars
and Fine Lines

- Phototherapy Center
- Psoriasis
- Vitiligo
- Atopic Dermatitis
- Eczema
- Pruritus

- Cosmetic Dermatology
- Botax Cosmetic
- Restylane • Juvederm • Perlane
- Laser Treatments
- DermiSpa
- Skin Rejuvenation Programs
- Peels
- Javanl Facials
- Microdermabrasion
- Wrinkle Treatments
- Lipodissolve Ultra
- Mesotherapy
- AFT Photo Facials
- Eyelash Treatments

HIPAA
Acknowledgement of Receipt

Patient's Name

Date of Birth

My signature below indicates that I have been provided with a copy of the
Notice of Privacy Practices.

X

Patient or Responsible Party Signature

Today's Date

1185 Town Centre Drive
Suite 101
Eagan, Minnesota 55123

Appointments: 651.209.3600
Fax: 651.209.3601

www.CrutchfieldDermatology.com



PLEASE PRINT PATIENT'S NAME

Date of Birth

Patient Satisfaction Agreement

Dr. Charles Crutchfield III, MD and Crutchfield Dermatology, PA (collectively called "Crutchfield Dermatology") hold your satisfaction as our top priority. If at any time during your communication with our staff, your treatment by our medical professionals, or any service follow up you have a question, issue, or concern, we want to do everything possible to answer your questions or address your issues and concerns.

We also take pride in Crutchfield Dermatology's reputation for excellence and our great standing in the community, and we are committed to earning the positive reputation and maintaining that standing every day. As we agree to work as hard as we can to meet your satisfaction, you agree to report any question, issue, or concern you have related in any way to the care we have provided to our Satisfaction Director at (651) 209-3600 or at satisfactiondirector@crutchfelddermatology.com. You further agree to follow the following process ("Patient Satisfaction Agreement Procedures") prior to any disclosure of the matter by you to third parties.

First, you agree to provide Crutchfield Dermatology 30 days from the time you provide notice of your concern to our Satisfaction Director as described above. Second, Crutchfield Dermatology is a proud member of the Better Business Bureau. In the event we are unable to resolve a matter to your satisfaction within 30 days as described above, you agree to submit your concern to the Better Business Bureau for a determination regarding your concern. Finally, if you believe your concern remains inadequately addressed after these time periods and processes, you agree to provide Crutchfield Dermatology with a written copy of any communication you plan to disseminate regarding an unresolved issue prior to doing so. You also authorize the Clinic to verify the source of any such communication from you to ensure concerns and issues are properly reported to permit us to address such matters in the future. You further agree that a failure to follow the above policy entitles Crutchfield Dermatology to equitable relief.

No-Show and Cancellation Policy

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointments with Crutchfield Dermatology are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs and to contain our fees, we maintain a No Show/Cancellation Policy for all our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance. Cancellations must be made between 8 a.m. and 5 p.m. on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the telephone by speaking directly to one of our scheduling professionals, who will provide a cancellation number. Patients will not be charged for an office visit if cancellation is made 24 business hours before their appointment and a cancellation number is received.

In the event an appointment is missed or cancelled with less than 24 hours notice or no notice, a \$75 charge will be billed. If a second no-show or same day cancellation occurs, we reserve the right to terminate the patient-doctor relationship.

This policy is in effect for all appointments at our office, including clinical, laboratory, cosmetic, and phototherapy appointments. Again, all no-shows or same-day cancellations will be invoiced \$75 if not cancelled with a 24 business hour notification with a received cancellation code.

Finally, you acknowledge that you have had an opportunity to review this agreement with the counsel of your choosing. This agreement shall be valid and enforceable for five years from Crutchfield Dermatology's last date of service to you. Crutchfield Dermatology reserves the right to modify any policies without notice.

My signature below indicates that I have read and understand these policies.

 X

Patient or Responsible Party Signature

Today's Date

Patient History

Patient's Name

Date of Birth

* I prefer to be called

Today's Date

1. _____

2. _____

3. _____

Reason/s for Today's Visit Duration of Condition/s

**Past Medications Used
For This Condition:**

Past Medical History:

- Any Dermatologic Problems
- Arthritis Conditions
- Asthma
- Cardiac Diseases
- Diabetes
- Eczema
- Hypertension
- Lipid Disorders
- Musculoskeletal Problems
- Skin Cancer
- Thyroid Disorder
- Cancer
- Pacemaker/Implanted Device
- Other

Allergies:

- Adhesive Tape
- Latex
- Lidocaine/Novacaine
- Nickel
- Perfume
- Poison Ivy
- Sunlight

Family History:

- Any Dermatologic Problems
- Skin Cancer

List Allergies to Medications:

Social History:

_____ Do you drink alcohol?
_____ If yes, how often?
_____ Do you smoke?

Current Medications:

Female Patients Only:

_____ Are you pregnant?
_____ Are you breast feeding?

Medical History Review of Systems

Please check all that currently apply to you:

- Abdominal cramps
- Breathing difficulties
- Bruising
- Chills
- Cold intolerance
- Constipation
- Depression
- Diarrhea
- Dizziness
- Dry eyes
- Dry lips
- Dry skin
- Epigastric pain (stomach pain)
- Extreme thirst
- Fatigue
- Fever
- Cold or Flu-like symptoms
- Hair loss
- Headaches
- Heat intolerance
- Joint pain
- Muscle weakness
- Nail changes
- Nausea
- Night sweats
- Nose bleeds
- Pain
- Pruritus (itchiness)
- Shortness of breath
- Sleep problems
- Sore throat
- Swollen lymph nodes
- Systemic Malignancy (Cancer)
- Weight change
- Yeast infections
- None**



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- Psoriasis
- Skin Cancer
- Mole Checks
- Skin Exams
- Warts
- Rashes
- Pediatrics
- Skin Surgery
- Ethnic Skin
- Vitiligo

Laser Surgery

- Acne
- Birthmarks (PortWine)
- Warts
- Unwanted Hair
- Facial Veins
- Sun Damaged Skin
- Age Spots
- Wrinkles
- Pixel Laser for Acne scars
and fine lines

Phototherapy Center

- Psoriasis
- Vitiligo
- Atopic Dermatitis
- Eczema
- Pruritus

Cosmetic Dermatology

- Botox Cosmetic
- Restylane • Juvederm • Perlane
- Laser Treatments
- DermiSpa
- Skin Rejuvenation Programs
- Peels
- Juvani Facials
- Microdermabrasion
- Wrinkle Treatments
- Lipodissolve Ultra
- Mesootherapy
- Photo Facials

**Request for Family Member to have Access to Protected
Health Information**

Patient's Name

Date of Birth

I, _____
authorize Crutchfield Dermatology to disclose my Protected Health Information
(PHI) including billing information, to the following family members:

<u>Name</u>	<u>Relationship</u>
1. _____	_____
2. _____	_____
3. _____	_____

I understand I may revoke this authorization by sending a written request for
revocation to Crutchfield Dermatology. I understand that when Crutchfield
Dermatology discloses this information pursuant to this authorization; the
information may no longer be protected by federal or state privacy rules and
may be subject to re-disclosure by the recipient of the information.

I understand and agree to the terms of this authorization:

X

Patient or Responsible Party Signature

Today's Date

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Eagan, Minnesota 55123

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Cosmetic Interest Questionnaire

Patient's Name

Date of Birth

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- Microdermabrasion
- Wrinkle Treatments
- Lipodissolve Ultra
- Mesotherapy
- AFT Photo Facials

Our practice is constantly striving to offer you the safest, most advanced procedures for facial rejuvenation and overall physical improvement. Please check any of the following health issues that you would like to receive more information on, or to schedule a consultation with Dr. Crutchfield:

- Forehead
- Lip Enhancement
- Frown Lines
- Crow's Feet
- Marionette Lines
- Sun spot/freckles
- Overall Skin Rejuvenation
- Medical skin care products/make up
- Treatment for unwanted facial lines
- Unwanted fat/cellulite
- Treatment for spider veins/facial veins
- Laser hair removal
- Excessive sweating: _____ under arms _____ hands _____ feet
- Other/Specific treatments: _____
- I would like to schedule a consultation with Dr. Crutchfield about: _____

Would you like to receive information via email or USPS mail?

- Yes
- No

If YES, please list email address: _____

If YES, what address can we send it to? _____

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