

**REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND
SIGNATURE ON FILE**

Patient Name: _____ Today's Date ____/____/____

Other family members that are patients _____

Primary Care Physician (Dr. Name and Clinic): _____

In case of Emergency, who should be notified? _____ Phone: () _____

Please be advised: Charles E. Crutchfield III, MD is a Clinical Associate Professor of Dermatology at the University of Minnesota. Often times, he will have a physician or student physician following him. We will be sensitive and accommodating to your concerns. If you are uncomfortable with this, please inform your nurse.

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date ____/____/____

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual \$100.00 deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed the remaining balance.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

HMO, PPO or other managed care patients and all other patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic/medical services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35 % of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Minor Children: The parent or guardian bringing the child to the office for their visit is responsible for payment independent of what a divorce doctrine may state. Reimbursement must be made between divorced parents. We will not intervene.

Patient or Responsible Party Signature _____ Date ____/____/____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers of Medicare and Medicaid Services 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.

Signature as it appears on Medicare Card _____ Date ____/____/____

If you have a supplemental policy and it is a **MEDIGAP** policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature 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.

Signature as it appears on MEDIGAP Card _____ Date ____/____/____

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



Crutchfield Dermatology Patient Satisfaction Agreement and No-Show and Cancellation Policy

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

Reason/s for Today's Visit

Duration of Condition/s

1. _____

2. _____

3. _____

Past Medications Used For This Condition:

Current Medications:

Allergies:

Adhesive Tape

Latex

Lidocaine/Novacaine

Nickel

Perfume

Poison Ivy

Sunlight

List Allergies to Medications:

Past Medical History:

Any Dermatologic Problems

Arthritis Conditions

Asthma

Cardiac Diseases

Diabetes

Eczema

Hypertension

Lipid Disorders

Musculoskeletal Problems

Skin Cancer

Thyroid Disorder

Cancer Type _____

Past Medical History continued:

Pacemaker/Implanted Device

Other _____

Family History:

Any Dermatologic Problems

Skin Cancer

Social History:

Do you drink alcohol?

Yes No

If yes, how often? _____

Do you smoke?

Yes No

If yes, how much per day? ____

Female Patients Only:

Are you pregnant?

Yes No

Are you breast feeding?

Yes No

Have you had a hysterectomy?

Yes No

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	

Cosmetic Interest Questionnaire

Patient's Name

Date of Birth

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? _____

**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