

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 Medication Used for this Condition: _____

Current Medications: _____

Allergies:

Adhesive Tape Latex Lidocaine/Novacaine Nickel Perfume Poison Ivy Sunlight

Please List Allergies to Medications:

Past Medical History:

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

Family History:

Any Dermatologic Problems Skin Cancer Adopted

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

Circle all that apply:

- 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
-
- Nausea
- Night Sweats
- Nail Changes
- Nose Bleeds
-
- Pain
- Pruritus(itchiness)
-
- Shortness of Breath
- Sleep Problems
- Sore Throat
- Swollen Lymph Nodes
- Systematic Malignancy (Cancer)
-
- Weight Change
-
- Yeast Infections

PATIENT INFORMATION

New Patient Name Change Address Change Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Today's Date ____/____/____

Legal Name: _____
Last First Middle Initial Prefer to be Called

Date of Birth: _____ Age: _____ Social Security #: _____ Sex: Male Female

Mailing Address: _____
Street Address City State Zip

Marital Status: Single Married Divorced Widowed Separated

REFERRED BY: _____

**As a service to our patients, we provide courtesy appointment reminders and other important communication through a pre-recorded message, text message, or email. By providing the below telephone numbers and email address, you consent to receiving such communication from your healthcare provider. You may opt out of receiving some or all of these communications by notifying the clinic in writing at any time or replying "Stop" to the automated system.*

Home Phone: () _____ DO NOT leave detailed medical message

Cell Phone: () _____ DO NOT send text reminders

Work Phone: () _____ DO NOT leave detailed medical message

Primary E-mail Address: _____ DO NOT send email reminders

Patient's Occupation: _____

State and federal law requires we ask the following questions:

<u>Primary Language (circle one):</u>	<u>Race (circle one):</u>	<u>Ethnicity (circle one):</u>
English	Caucasian	Hispanic or Latino
Spanish	Hispanic	Not Hispanic or Latino
Somali	Asian	
Other (please specify) _____	African American	
	Other (please specify) _____	

RESPONSIBLE PARTY (if different from patient)

Name: _____
Last First Middle Initial

Address: _____
City State Zip

Home Phone: () _____ Work Phone: () _____

Date of Birth: ____/____/____ Social Security #: _____ Sex: Male Female

X _____
Patient or Responsible Party Signature

____/____/____
Today's Date

INSURANCE COVERAGE

INSURANCE COVERAGE – PRIMARY

Insurance Co. Name: _____ Phone: () _____ Ext: _____

Address of Claim Center:

Name Policy Holder (Insured): _____ City _____ State _____ Zip _____
Date of Birth: ____/____/____

Policy #: _____ Group Name or #: _____

Policy Type: HMO PPO Employer Name: _____

Employer Address: _____

If patient is a child, check relationship: Mother Father Other _____

INSURANCE COVERAGE - SECONDARY

Insurance Co. Name: _____ Phone: () _____
Ext: _____

Address of Claim Center:

State _____ Zip _____ City _____

Name Policy Holder (Insured): _____ Date of Birth: _____
____/____/____

Policy #: _____ Group Name or #: _____

Policy Type: HMO PPO Employer Name: _____

Employer Address: _____

If patient is a child, check relationship Mor Faer Other _____

X _____
Patient or Responsible Party Signature

____/____/____
Today's Date

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

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

Other family members that are patient's _____

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 Professor of Dermatology at the University of Minnesota. Often times, he will have a physician or student physician following him.

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 ____/____/____

AUTHORIZATION 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 all medical and billing information, to the following family members:

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

I understand that this **authorization remains valid for one year from today's date**. 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.

I understand and agree to the terms of this authorization:

X _____ ____/____/____
Patient or Responsible Party Signature **Today's Date**

HIPPA – ACKNOWLEDGEMENT OF RECEIPT – see “Notice of Privacy Practices”

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

PATIENT SATISFACTION AGREEMENT, NO-SHOW POLICY, AND CANCELLATION POLICY

_____/_____/_____
Patient's Name (PLEASE PRINT)

_____/_____/_____
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 take pride in Crutchfield Dermatology's reputation for excellence and standing in the community and are committed to 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 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 and to follow the "Patient Satisfaction Agreement Procedures" outlined below prior to any disclosure of the matter by you to third parties.

First, you agree to provide Crutchfield Dermatology 30 days from communicating your concern to our Satisfaction Director to review and address your matter. Second, Crutchfield Dermatology is a proud member of the Better Business Bureau. If 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 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 authorize the Clinic to verify the source of any communication from you to ensure your authorship and to permit us to address such matters in the future. You further agree that failure to follow this policy entitles Crutchfield Dermatology to equitable relief.

No-Show and Cancellation Policy

Our appointment times are scheduled to address each individual patient's needs. Since appointments with Crutchfield Dermatology are in high demand, we value advance notice from patients unable to keep their scheduled appointments.

To maximize patient access and decrease unnecessary costs, we maintain a No Show/Cancellation Policy for all our patients that requires any appointment that is no longer needed or unable to be kept 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 appointment. Cancellations must be made over the telephone by speaking directly to one of our scheduling professionals. Cancellations done by selecting a cancellation response on our automated appointment reminder system are also acceptable. Patients will not be charged for an office visit if cancellation is made at least 24 business hours before their appointment. If you cancel an appointment with more than a 24 hours' notice on a business day, you will receive a cancellation number which is necessary to verify that you provided proper notification.

In the event an appointment is missed or cancelled with less than 24 hours' notice as described above ("missed appointment"), Crutchfield Dermatology reserves the right to terminate the patient-doctor relationship. If a patient has two or more missed appointments, you will be notified of termination of the patient-doctor relationship. This policy is in effect for all appointments at our office, including clinical, laboratory, cosmetic, and phototherapy appointments. By signing below, you acknowledge and agree that the patient-doctor relationship may be cancelled due to one or more missed appointments.

Finally, we advise you to review this agreement with the legal counsel of your choosing. By signing this agreement you acknowledge that you have had an opportunity to review this agreement with the counsel of your choice if you desire to do so. 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

PERSONAL NOTE FOR YOU FROM CRUTCHFIELD DERMATOLOGY AND WAIT TIMES

Dr. Crutchfield loves to help patients with all their skin care needs. The high demand for dermatology care and Crutchfield Dermatology's commitment to addressing each patient's needs may lead to longer than anticipated wait times. Please note you may experience a delay in being seen by Dr. Crutchfield and should allow ample time when scheduling with us to avoid conflicts if an appointment runs long.

If you believe the best care is worth a little flexibility, we promise to do all we can to get you the best quality care as timely as possible.

We could not be more honored to have you here!

Sincerely,
Charles E. Crutchfield III, M.D.
And the entire staff of Crutchfield Dermatology