VANGUARD SKIN SPECIALISTS

DERMATOLOGY • DERMATOPATHOLOGY • MOHS MICROGRAPHIC SURGERY • PLASTIC SURGERY

**Patient Information:**

Patient Name: _____

Date of Birth: _____ Sex: _____

Mailing Address: _____

City, State, and Zip Code: _____

Race(optional): _____Ethnicity (optional):_____

Preferred Language: _____

Primary Care Doctor: _____

Primary Insurance: _____Secondary: _____

**I authorize Vanguard Medical Specialists, LLC to contact me as follows (check all that apply):**

- ☐ Call and leave message on cell
- ☐ Call and leave message on home
- ☐ Call and leave message on work
- ☐ Text cell
- ☐ Call and leave message with family
- ☐ I do not authorize any messages

Home Phone#: _____Cell#:_____

Email Address: _____Work#:_____

Please number the contact options in your order of preference (1st through 4th or N/A)

Home: _____ Cell: _____ Work:_____Email: _____

**I authorize Vanguard Medical Specialists, LLC to leave phone messages containing pathology reports:**

- ☐ No.
- ☐ Yes, on: **(circle all that apply)** Home phone Cell phone Work phone

**I authorize Vanguard Medical Specialists, LLC to release my protected health information (including pathology reports) to my family members:**

- ☐ No.
- ☐ Yes. _____

(Name of family member[s] to whom information may be released)

**Emergency Contact Name**: _____

Relationship to Patient: _____ Phone Number: _____

**Guarantor Name (person bringing in patient today):** _____

**Relationship to Patient:** _____

**Address (if different):**_____ **Phone if Different:**_____

**Pharmacy Information:**

Pharmacy Name/Location: _____

**By signing this authorization, I verify the accuracy of my demographic information. I also authorize Vanguard Medical Specialists, LLC to share my protected health information (PHI) with the physicians I have listed on this form.**

_____

Name (printed) Signature Date

## PATIENT CONSENT FORM AND FINANCIAL POLICY

**Use and Disclosure of Protected Health Information**
Vanguard Medical Specialists, LLC (also referred to as "the Practice" within this form) may use and disclose protected health information (PHI) or individually identifiable health information (IIHI) about the patient to carry out treatment, payment and healthcare operations (TPO). Please refer to the Practice's Notice of Privacy Practices for a more complete description of such users and disclosures. I have the right to obtain a copy of the patient's medical records by sending the practice a written request. I may also access the patient's records through the online patient portal if I choose to use it.

I have reviewed the Notice of Privacy Practices prior to signing this consent. Vanguard Medical Specialists, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Vanguard Skin Specialists, 9348 Grand Cordera Pkwy, Ste 160, Colorado Springs, CO 80924.

Vanguard Medical Specialists, LLC may call or text my home or other designated location, including the patient's emergency contact if I cannot be reached, and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to the patient's clinical care, including laboratory results among others.

Vanguard Medical Specialists, LLC may mail and/or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, medical information, and patient statements.

I have the right to request that Vanguard Medical Specialists, LLC restrict how it uses or discloses the patient's PHI/IIHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement until other written notice is given.

By signing this form, I am consenting to Vanguard Medical Specialists, LLC's use and disclosure of the patient's PHI/IIHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

**Consent for Treatment**
By signing this form, I am giving my permission for the doctors and staff of *Vanguard Medical Specialists, LLC* to treat the patient with your verbal consent, including biopsy or procedure(s), as deemed necessary in the exercise of their professional judgment. This may include obtaining medical records from other doctors' offices and medication history from external sources, e.g., Surescripts, pharmacies, etc. Medical care requires your cooperation, so it is important that you follow the doctor's orders, prescriptions, make and keep appointments for follow up care (as indicated), and call the office to note any changes in or concerns about your condition.

**Photographs**
The patient's physician and the Practice may take photographs to record the patient's surgery/procedure(s). Reproduction or publication of said photographs and recordings will be used for the purpose of medical/scientific study and research, education, before and after surgical portfolios, and/or documentation for your medical record.

**Payment for Service**
I understand that I am solely responsible for paying the full amount for all services on the day of service, unless the Practice has an agreement with the patient's insurance carrier. For insured patients, my share of the service, e.g., co-payments and deposits toward unmet deductibles, will be collected upon check-in. Wound check and suture removal visits are billed visits, depending on the type of surgery and the patient's insurance. **If the patient is in a grace period with his/her insurance carrier, we will collect payment on the day of his/her appointment for all services provided.**

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**Please initial**_____

**Insurance Claims**
For insured patients, the Practice may release any information, including the diagnosis and the records of any treatment or examination rendered to the patient during the period of such medical care to third party payers, including Medicare. The patient's insurance company will pay to the doctor or medical group any benefits for services rendered. The patient's medical insurance carrier may pay less than the actual fees for services, in which case you are solely responsible for payment of all services rendered. As a courtesy, the Practice will file insurance claims with standard carriers. You are responsible for making available complete insurance information for accurate filing of claims. Reduction or rejection of your claim by the patient's insurance company does not relieve the financial obligation you have incurred**.** It is to your advantage, as well as your responsibility, to know and understand the patient's medical insurance coverage. Not all services are a covered benefit in all contracts. **Dermatology is not considered preventative by most insurance carriers.** Please call the patient's insurance company to verify the patient's benefits. As a courtesy, our staff verifies benefits for surgery, but there can be misquotes and or misunderstandings—insurance companies do not guarantee payment when we call for authorization. You will be responsible for all fees not paid by the patient's insurance company.

**Referrals and Authorization**
As a specialist, some insurance companies (particularly HMOs and Tricare) require that prior to any visit you must obtain an authorization or referral from the patient's primary care physician. It is your responsibility to know if this is required for the patient's insurance and if so, to procure the referral. If this is not done by the day of the patient's appointment, you will be asked to either reschedule the patient's appointment after contacting his/her primary care physician, or pay for the services at the time he/she are seen. If the patient's insurance company rejects a claim because a valid authorization or referral was not in place, the full cost of the visit will be solely your responsibility.

**Financial Assistance**
For patients with financial need, we offer a financial assistance program for the treatment of skin cancers. Please ask a member of our staff for more information.

**ADDITIONAL CHARGES FOR WHICH YOU MAY BE RESPONSIBLE**

**Laboratory Fees**
You may receive a separate bill. The practice may use an outside laboratory, for biopsies, wound cultures, and other incidental tests. For insured patients, we will provide the laboratory with the patient's insurance information. The pathology services typically range from $110 to $250 per specimen. The cost can be substantially higher if additional tests or a second opinion is required. For example, an unusually complex case may require a special stain and/or second opinion which will significantly increase the cost per specimen.

**Scheduling Fees**
If you are unable to keep the patient's scheduled appointment, please contact our office at least 24 hours in advance. We reserve the right to charge $25.00 for any appointment which is not cancelled with proper notice. Surgery and patch appointments that are not cancelled with proper notice will be charged $50.00. Additionally, ***we will not continue to see patients who have no showed, or cancelled or rescheduled within 24 hours of their appointment 3 times.***

**Unpaid Account Balances**
We send patient statements monthly. All accounts unpaid after two statements will accrue an additional $25.00 transfer fee and be transferred to an outside collections agency to manage the collections process. Any returned checks or cancelled credit card charges will incur a fee of $25.00.

**Patient Guarantor Agreement:** *I have read the above form and agree to the terms stated. I hereby acknowledge receipt of Vanguard Medical Specialists, LLC's Notice of Privacy Practices. I realize that payment is solely my obligation, regardless of insurance or third party involvement.* **Signing of the financial consent form and financial policy is acceptance of all terms as they are written. No amendments or modifications will be granted.**

_____
Guarantor Name (printed)

_____ _____
Guarantor Signature Date

## Vanguard Skin Specialists
## 24 Hour Appointment Cancellation Policy

If you are unable to keep the patient's scheduled appointment, please contact our office at least 24 hours in advance. If you do miss, cancel, or reschedule an appointment with less than 24 hours' notice, our cancellation policy is as follows:

- **1st Instance:** We understand that life happens and schedule conflicts may arise unexpectedly. The first instance of a missed, cancelled, or rescheduled appointment within 24 hours of your scheduled appointment time will not be counted against you and no fee will be charged.
- **2nd Instance:** We will charge $25 which must be paid prior to rescheduling. If your insurance does not allow the collection of a charge, you will have to wait 60 days to reschedule your appointment.
- **3rd Instance:** The third instance will result in a dismissal from our practice. You will have to wait 3 years to reschedule.

Due to the high cost of allergens, patch appointments that are not cancelled with proper notice will always be charged $50. Surgery and aesthetic appointments are also charged a fee of $50.

Severe weather is excluded from the cancellation policy.

By signing below, you acknowledge that you have read and understand the Cancellation Policy for Vanguard Skin Specialists as described above.

_____ _____

Guarantor Signature Date

**Welcome to Vanguard Skin Specialists! We are committed to providing you with the highest quality patient care and experience. Please let any staff member know if we can do anything to make your visit more pleasant.**

**Thank you for entrusting us with your medical care.**

(1) How did you hear about Vanguard Skin Cancer Specialists? (Check all that apply)

**Media/Advertising**

- ☐ Flyer or Sign. Location _____
- ☐ Internet
- ☐ Colorado Springs Style
- ☐ Newspaper
- ☐ Postcard or letter in the mail
- ☐ Radio
- ☐ Pandora
- ☐ Television
- ☐ Yellow pages

**Word of mouth**

- ☐ Referral from another doctor
- ☐ Referral from another patient. Patient's name _____
- ☐ Other word of mouth. Please describe _____

**Other sources**

- ☐ Drove by the office and saw the sign
- ☐ Listed as part of insurance company network
- ☐ Other. Please describe _____

(2) Who is the patient seeing today?

- ☐ David Archibald, MD
- ☐ James Banich, MD
- ☐ Landon Barton, PA-C
- ☐ Vinh Chung, MD
- ☐ Rachel Frederickson, PA-C
- ☐ Jennifer Garrick, FNP-BC
- ☐ Shea Kersh, PA-C
- ☐ Michael Leslie, MD PhD
- ☐ Renata Prado Oliveira, MD
- ☐ Emily Reynolds, FNP-BC
- ☐ Maria Sheron, MD
- ☐ Megan Stimpson, PA-C

(3) What is the reason for the patient's appointment today? (Check all that apply)

- ☐ Mohs Micrographic Surgery & Other Skin Cancer Surgeries
- ☐ Non-Skin Cancer Surgery (Examples: Excision/Cryosurgery for Pre-malignant & Benign Lesions)
- ☐ Skin Exam or Diagnosis of Potential Skin Cancer
- ☐ Cosmetic Service (Examples: Botox, Dermabrasion, Reconstruction)
- ☐ Other Dermatology Concern (Examples: Acne, Warts, Rashes)