IDAHO SKIN SURGERY CENTER

1906 S. Vista Ave, Boise, ID 83705
208.433.1114 **Phone**
208.433.1115 **Fax**

975 NW 16th St, Fruitland, ID 83619
208.452.7450 **Phone**
208.452.7550 **Fax**

idahoskinsurgerycenter.com

Jared Scott, MD
Jessie Zimmerman, PA-C
Katelyn Wade, PA-C
Logan Hawker, PA-C
Brittney Irons, FNP-C

Dear Patient,

Thank you for choosing Idaho Skin Surgery Center, PC for your skin care and dermatologic needs. Our providers strive to provide the best quality and highly personalized care to all of our patients. For our New Patients, we would like to provide you with some information to make your visit with us smoother and more enjoyable.

Directions: Detailed directions and maps to each of our offices can be found on the following pages.

New Patients: Please arrive 15 minutes prior to your scheduled appointment time to ensure that your paperwork is completed. We enclosed the New Patient Paperwork for your convenience. Please complete and bring with you to your appointment. Alternatively, you may also download all of our forms at our website www.idahoskinsurgerycenter.com under the Forms tab. You will be required to have a Photo ID as well as your Insurance Card(s) at your visit. We will scan them into your chart and keep them on file. If you arrive 15 minutes or more after your scheduled appointment time, we reserve the right to reschedule your appointment.

Reminders: As a courtesy to our patients, we will give you a confirmation call 2 days prior to your scheduled visit and a text message(cell phones only)1 day prior. Please provide 24 hours or more advance notice if you wish to cancel your appointment.

Questions: If you have any questions, please feel free to contact our office or you can visit our website at www.idahoskinsurgerycenter.com. Our providers and staff look forward to caring for your dermatology and skin care needs. Thank you for choosing Idaho Skin Surgery Center, PC.

Sincerely,

Idaho Skin Surgery Center Staff

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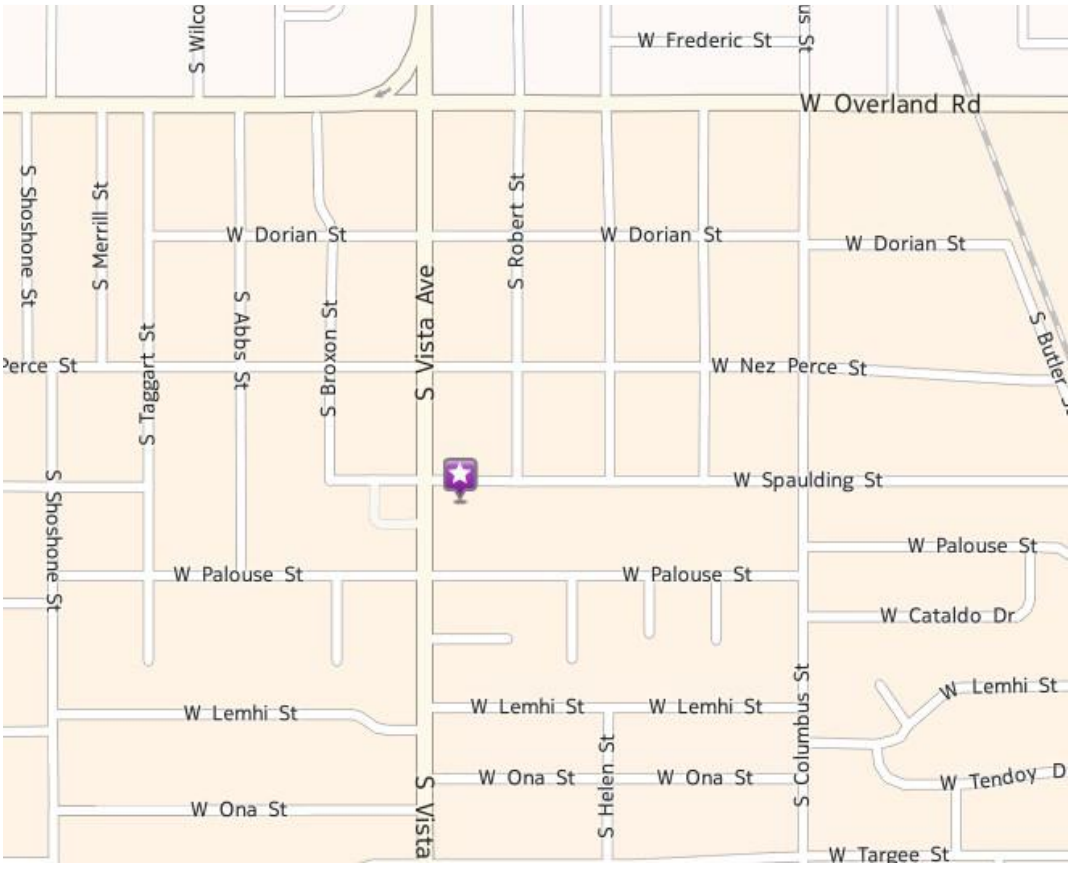
Boise Office

From West or East of Boise – From I-84, take exit 53/Vista Ave (the Airport Exit) and turn North onto Vista Ave (away from the airport). Continue down Vista for approximately 1 mile. Turn right onto W Spaulding Ave, then 1st right into parking lot.

From Downtown/North Boise – Go south on N 9th St (towards the airport). 9th St becomes S Capitol Blvd. Continue onto S Capitol Blvd, veer left and continue up the hill, then veer left again and Capital Blvd becomes Vista Ave. Continue south for approximately 1 mile. Turn left onto W Spaulding Ave, then make 1st right into parking lot.

From Northwest Boise – Take the Connector/I-184 west to I-84, then head east towards the airport. Take exit 53/Vista Ave (the Airport Exit) and turn North onto Vista Ave (away from the airport). Continue down Vista for approximately 1 mile. Turn right onto W Spaulding Ave, then 1st right into parking lot.



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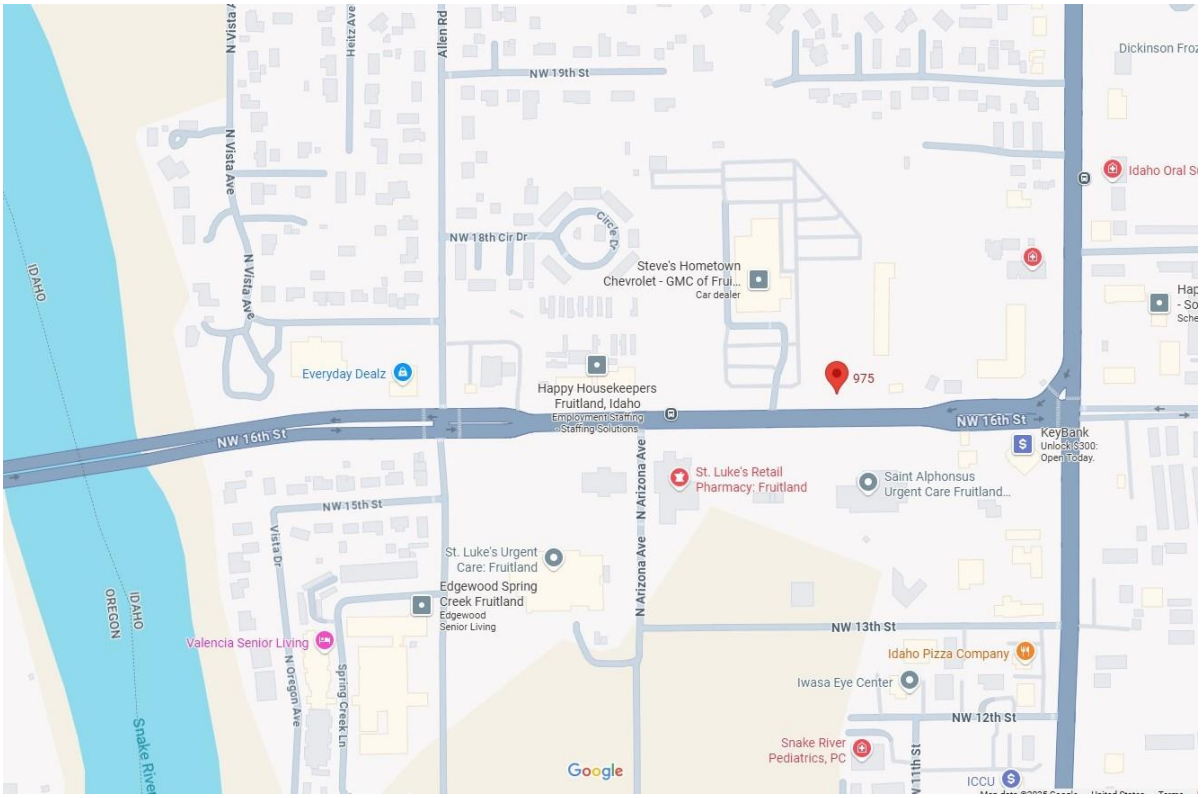
Fruitland Office

From Boise – From I-84 W, take exit 376B toward US-30 E/Fruitland/Payette. Turn right onto E Idaho Ave (US-30) which turns into NW 16th St. Building will be on the left-hand side just past the GMC Dealer and directly across from St. Alphonsus.

From Baker – Take the US 30 E/Elm St to merge on to the I-84 E via the ramp to Ontario. Follow the I-84 E to US-30 E/E Idaho Ave in Ontario taking exit 376B towards Payette. Continue on NW 16th St. making a left into 975 NW 16th St. Building will be on the left-hand side just past the GMC Dealer and directly across from St. Alphonsus.

From Ontario – Take E Idaho Ave to the US 30 E. which will turn into NW 16th St. Building will be on the left-hand side just past the GMC Dealer and directly across from St. Alphonsus.



IDAHO SKIN SURGERY CENTER

HISTORY AND INTAKE FORM

Patient Name	DOB	Race	Ethnicity □ Decline □ Hispanic □ Not Hispanic
Primary Care Physician	Referring Physician		Preferred Pharmacy (name and location)
Reason for today Visit:			

Past Medical History (please check all that apply)		
□ None	□ Depression	□ Immunosuppressive therapy
	□ Diabetes	□ Hepatitis
□ Anxiety	□ Thyroid Disease	□ Leukemia
□ Arthritis	□ End-stage renal disease	□ Lymphoma
□ Asthma	□ hay fever	□ Colon Cancer
□ Atrial fibrillation	□ hypertension	□ Myocardial infarction (Heart Attack)
□ Autoimmune disease	□ Hearing loss	□ Radiation Therapy
□ Cerebrovascular accident (Stroke)	□ Heart disease	□ Seizure
□ Chemotherapy	□ HIV/AIDS	
□ COPD	□ High cholesterol	□ Other

Past Surgical History (please check all that apply)	
□ None	□ Oophorectomy
□ Pacemaker/Defibrillator	□ Transplantation of kidney
□ Artificial Joint: _____Year:_____	□ Transplantation of lung
□ Tubal ligation	□ Transplantation of heart
□ Heart valve replacement: □ Biological □ Mechanical	□ Transplantation of liver
□ Hysterectomy	□ Other

Skin Disease History (please check all that apply)		
□ None	□ Dysplastic/Atypical Moles	□ Squamous cell carcinoma
□ Acne	□ Eczema	□ Sunburn of second degree (Blistering)
□ Actinic keratosis	□ Melanoma	
□ Basal cell carcinoma	□ Psoriasis	
□ Dry skin	□ Rosacea	□ Other

Do you wear sunscreen? □ Yes □ No If Yes, what SPF? _____

Do you tan in a tanning salon? □ Yes □ No

Do you have a family history of Melanoma? □ Yes □ No If yes, which relative(s)?

Current Medication (May attach list of medications if preferred)

List any medications that you are currently taking. Include items as aspirin, vitamins, laxative, etc)

□ No Medications

Name of medication	Dose (strength and # per day)	Name of medication	Dose (strength and # per day)
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Do you give us permission to request prescription history information electronically from your pharmacy? □ Yes □ No

Allergies/Sensitivities

□ No Known Allergies			
Name of medication	Reaction	Name of medication	Reaction
1.		4.	
2.		5.	
3.		6.	

Social History

Smoking Status: □ Current every day smoker □ Current some day smoker □ Former smoker □ Never smoker

Weekly alcohol intake: □ None □ Casual drinker or less than 1 drink per day □ 1-2 drinks per day □ 3 or more drinks per day

How many times per year do you have 5+ drinks in one day? _____

(Continued on next page)

Quality Measures (for patients 65 or older)			
Do you have a health care proxy in the event that you are unable to make your own medical decisions? □ Yes □ No			
Do you have a living will? □ Yes □ No			
Which of the following statements reflects your wishes on advanced care recommendations? □ Do not intubate. I do not wish to have a breathing tube, even if it is necessary to save my life. □ Do not resuscitate. If my heart were to stop, I do not wish to have chest compressions or an AED to restart my heart. □ Full Cardiopulmonary Resuscitation. I want full cardiopulmonary resuscitation effort to be made.			
Review of systems: Are you CURRENTLY experiencing any of the following?			
new, non-healing, or changing skin lesion(s)	□ Yes □ No	dry skin	□ Yes □ No
enlarged nodes, glands, or SQ nodules	□ Yes □ No	bloody nose	□ Yes □ No
fever or chills	□ Yes □ No	depression	□ Yes □ No
night sweats	□ Yes □ No	suicidal thoughts	□ Yes □ No
unintentional weight loss	□ Yes □ No	vision problems at night	□ Yes □ No
difficult breathing or shortness of breath	□ Yes □ No	Irritated, dry or itchy eyes	□ Yes □ No
cough	□ Yes □ No	problems with bleeding	□ Yes □ No
skin changes/rash	□ Yes □ No	problems with healing	□ Yes □ No
visual changes	□ Yes □ No	problems with scarring (hypertrophic or keloid)	□ Yes □ No
chest pain	□ Yes □ No	sore throat	□ Yes □ No
pain in muscles, joints, or bones	□ Yes □ No	bloody urine	□ Yes □ No
abdominal pain	□ Yes □ No	bloody stool	□ Yes □ No
headaches	□ Yes □ No	wheezing	□ Yes □ No
nausea, vomiting, or diarrhea	□ Yes □ No		
Health Alerts (please list any that apply)			
□ Pregnant or planning pregnancy		□ Blood thinner	
□ Allergy to lidocaine		□ MRSA	
□ Rapid heartbeat with epinephrine		□ Allergy to adhesive	

I verify that the above information is true and accurate to the best of my knowledge.

Patient Signature:_____ Date:_____

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PATIENT INFORMATION FORM

Patient Information

Patient Name: Last, First, M.I.			Date of Birth	Social Security Number
Mailing Address	Street or PO Box	Apt, Ste., or Unit#	Gender (circle) Female Male	
City	State	Zip Code	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Partner	
2nd Seasonal Address	Street or PO Box	Apt, Ste., or Unit#	Email Address	
Home Phone#	Cell Phone#	Work Phone#	May we leave personal medical information on your voice mail? ☐ Yes ☐ No / ☐ Home ☐ Cell	

Patient Responsible for Charges

If person responsible for payment is different from patient, then complete below.
If patient is child, please indicate if parents are: ☐ Married ☐ Separated ☐ Divorced

Full Name: Last, First, M.I.			Social Security Number
Mailing Address	Street or PO Box	Apt, Ste., or Unit#	Date of Birth
City	State	Zip Code	Preferred Phone Number to Contact You:
Patient Relationship to the Responsible Party: ☐ Spouse ☐ Child ☐ Other			Work Phone:

Emergency Contact Information

In Case of Emergency Notify (Full Name):	Phone

Personal Representative

May we discuss your medical condition with another person? If yes, whom:

Insurance Information

Primary Insurance

Insurance Name: _____

Policy/ID#: _____

Group#: _____

Primary Policy Holders Name: _____

Date of Birth: _____SS#: _____

Address of Insured: _____

_____

Relationship to the patient: _____

Secondary Insurance

Insurance Name: _____

Policy/ID#: _____

Group#: _____

Primary Policy Holders Name: _____

Date of Birth: _____SS#: _____

Address of Insured: _____

_____

Relationship to the patient: _____

If Medicare is secondary, please specify the reason:

☐ Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
☐ Medicare Secondary Disabled Beneficiary Under Age 65 ☐ Other, Please Specify: _____

I hereby certify the above information is true and correct to the best of my knowledge and that I am the above-named patient or the duly authorized general agent of the above-named patient, authorized to furnish the information requested, and seek and authorize health care services. I understand that while Idaho Skin Surgery Center, PC contracts with many insurance companies, it is **MY** responsibility to verify with my plan that the physician I am seeing is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I further understand that Idaho Skin Surgery Center, PC. will assist me in obtaining authorization from my primary care physician or insurance company if necessary, however, ultimately it is my responsibility as the patient to determine if a prior authorization is required. If authorization is not obtained, I may be financially responsible for services rendered. I hereby authorize Idaho Skin Surgery Center, PC to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of insurance coverage. I hereby assign all applicable benefits and direct that payment to be made directly to Idaho Skin Surgery Center, PC, for all services provided to/for me during my visits. I acknowledge that photo ID's taken are used to assist in patient recognition per HIPPA guidelines. I authorize the doctor to release any medical information including diagnosis, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without further authorization signed by me for the release of the information. There will be a $6.50 charge for records requests. This fee is not required for transferring records to physicians who participate in your care or for insurance companies to complete payment of claims.

Patient or Responsible Party Signature: _____Date: _____

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Patient Portal Access

Thank you for choosing Idaho Skin Surgery Center for your dermatology and skin surgery needs. Because we use an electronic medical records system, we are required to provide online access to your medical records via a secure patient portal system. This portal is separate from other clinics and/or hospitals and will house your medical records from both our Boise office as well as our Fruitland office within the same portal.

Portal Features

- View upcoming appointments
- View or print medical records including chart notes, lab results, billing statements, etc.
- Update demographic information
- Update medical history information including medications and allergies
- Send message directly to your medical team
- New features frequently added

How to access my portal

By providing your email below, you will receive an email with s subject line "*Welcome to your Idaho Skin Surgery Center Patient Portal.* ***NOTE:*** The link is only valid for 72 hours, so you will need to "activate" your account within 72 hours.

- Within the email, click the "activate" button.
- This will open a new page requesting you to enter your DOB and last name.
- You will then be prompted to create your user name and password.
- You will now have access to all the features mentioned above.
- If you need help logging in to your portal once it has been set up, please contact our office and we can walk you through it.

Email: _____

Note: If an email is not provided, a generic username will be created and you will need to contact our office for instructions on how to access your portal.

Patient Signature: _____ Date:_____

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Financial Policy

Thank you for choosing Idaho Skin Surgery Center, PC (ISSC). for your dermatological care. We are committed to providing you with compassionate and quality health care. Payment of your bill is a part of your care. In order to avoid any misunderstandings, and to be completely transparent, we have provided you with the details of our financial policy below.

Insurance- We participate in most insurance plans including Medicare and Medicaid. Our clinic will make every effort to verify your insurance information that you provide. If we accept your insurance, and you do not have a current insurance card, payment will be due in full at the time of service until we can verify coverage. It will be your responsibility to contact your insurance company regarding your coverage. If your insurance changes, you will need to notify us before your next appointment so we can make the appropriate changes to your information and to ensure your claims get billed correctly for you to receive the correct benefits.

Proof of Insurance- If you are a new patient, you must complete our patient information forms before being seen by a provider. Occasionally, established patients will also need to update and complete the same forms. We also must obtain a current copy of your driver's license and a current insurance card to verify eligibility and file your claim.

Co-Payments and Deductibles- All co-payments must be collected at the time of service. This arrangement is part of your contract with your insurance company. If we fail to collect copays and/or deductibles, it is considered fraud. Please come prepared to pay your copay and/or deductibles.

Co-Insurance- This is also due at the time of service after your deductible has been met.

Payments- We accept payments by cash, check, debit card, Visa, MasterCard, Discover, American Express, FSA and HSA cards. All previous balances must be paid at time of service. If a check is returned for non-sufficient funds, and/or the payment was stopped, you will be charged a $35 fee, in addition to the amount of the check. For future visits, you may be asked to pay by cash, debit or credit card.

Payment Plans- We will no longer be offering payment plans through our office. If you feel that you may need a payment plan, we will refer you to ***AblePay***, which is a No-Cost program that has flexible payment options. Our staff are available to answer any questions you may have about ***AblePay.*** If you choose to use ***AblePay***, you will need to be signed-up with them **before** your visit(s). You cannot use ***AblePay*** for any cosmetic procedures such as Botox.

Self-Pay/Uninsured Patients- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes any related costs like medical tests, prescription drugs, equipment, and hospital fees. If you are a self-pay or uninsured patient, you will be given a verbal estimate of anticipated charges before or at the time of scheduling. Upon arrival to your appointment, you will be given a written Good Faith Estimate in which will include any reasonably expected or potential charges that may occur during this visit or at a future visit. Make sure to save a copy or picture of your Good Faith Estimate. If you receive a bill that is at least $400 more than your Good Faith Estimate, you have the right to dispute those charges either directly with your provider or through the Department of Health and Human Services (HHS). For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosuprises.

Claims Submission- Our office will submit your claims to the insurance company and assist you in any way we reasonably can to help you get your claim(s) paid. Your insurance may need you to supply certain information directly to them. It is your responsibility to comply with their request in a timely manner. As a patient/guarantor, you are responsible for payment whether or not your insurance pays your claim(s). Your benefits are a contract between you and your insurance company; we are not a party to that contract.

Non-Covered Services- Providers at ISSC may provide services that may not be covered as a benefit of your specific plan with your insurer. Coverage issues can only be addressed by your employer or group health administrator. Patients or guarantors are financially responsible for any and all services provided that may not be covered by your insurance plan. It is your responsibility to know and understand your specific plan and what benefits are provided. If we feel that the services will be non-covered, you must pay for these services at the time of service.

Minor Patients- The adult accompanying a minor and the parents/legal guardian of the minor are responsible for payment of services. If a minor is unaccompanied by an adult/legal guardian without prior payment arrangements, we will not be able to see the minor. If a child needs to be seen in our office with someone other than a parent/legal guardian, a "Consent to Treat a Minor" form must be signed by the parent/legal guardian *prior* to the minor being seen for non-emergency treatment. If our office does not have the form on file, the minor ***will not be treated***. You can obtain the form from our office personnel or at https://idahoskinsurgerycenter.com/forms/

Non-Payment- If you have a balance after your insurance has paid, we will send you a statement and the balance will be due within 30 days of the statement date. If your balance remains unpaid after 90 days, we will send you a letter by certified mail asking for payment within 10 days. Please note that if it remains unpaid after the 90 days, your account may be sent to an outside collection agency and you will be responsible for any fees associated with that agency.

No-Show Appointments- Any patient that does not show for their scheduled appointment and does not call to cancel or reschedule within 24hrs, may be charged a $25 fee. Any patient that does not show for their scheduled surgery appointment and does not call to cancel or reschedule may be charged a $200 fee. This will not be billed to your insurance, but directly to you. After three missed appointments, you may be dismissed from the practice.

Referrals- If you have insurance that requires a referral, we must have the referral in our office before you can be seen. It is your responsibility to obtain any/all referrals from your primary care physician. Patients who elect to be seen without a referral will be asked to pay for all charges in full at the time of service.

Refunds- No refunds will be issued until all dates of service are paid for. Once all dates of service are paid and there is a credit balance, we will make every effort to refund the balance within 30 days from the time the credit balance is discovered. If the credit balance was paid with a credit card, we will refund the balance back to the card that was used. If you paid with cash or check, we will refund the balance with a check. If the refund check is lost or misplaced and a stop-payment is required then there will be a $30 fee deducted from the check, if applicable.

_____ (initials) **I understand that I am financially responsible for the payment of medical charges incurred on my behalf with any medical provider at Idaho Skin Surgery Center, PC., regardless of third-party coverage.**

PRINT Patient Name **DOB**

SIGNATURE of Patient or Personal Representative **DATE**

IDAHO SKIN SURGERY CENTER

ASSIGNMENT OF BENEFITS

ALL COMMERCIAL INSURANCE CARRIERS

I authorize my insurance company to pay benefits on my behalf directly to Idaho Skin Surgery Center, PC. I authorize to provide my insurance company, any information necessary to process claims for services rendered to me.

_____ _____

Signature as it appears on your insurance card Date

****

MEDICARE

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.

_____ _____

Signature as it appears on your Medicare card Date

****

MEDIGAP

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 my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on your MEDIGAP card Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a
(Name of Patient)

copy of Idaho Skin Surgery Center, PC's **'Notice of Privacy Practices'.** This Notice describes how Idaho Skin Surgery Center, PC. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

_____ _____
Signature of Patient or Personal Representative) (Date)

_____
(Relationship to Patient)

Personal Representative (Family Members, Attorney, case worker, etc.): I hereby authorize Idaho Skin Surgery Center, PC and its employees to discuss, send and/or receive medical information to/with the following:

Please provide their names and phone numbers below:

1. Name _____ Relationship _____
Phone# _____

2. Name _____ Relationship _____
Phone# _____

3. Name _____ Relationship _____
Phone# _____