IDAHO
SKIN SURGERY
CENTER

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

811 NW 12th St, Fruitland, ID 83619
208.452.7450 **Phone**
208.452.7550 **Fax**

idahoskinsurgerycenter.com

Jared Scott, MD
Jessie Zimmerman, PA-C
Brittney Irons, FNP-C
Jeanna Rendo, NP-C
Katelyn Wade, PA-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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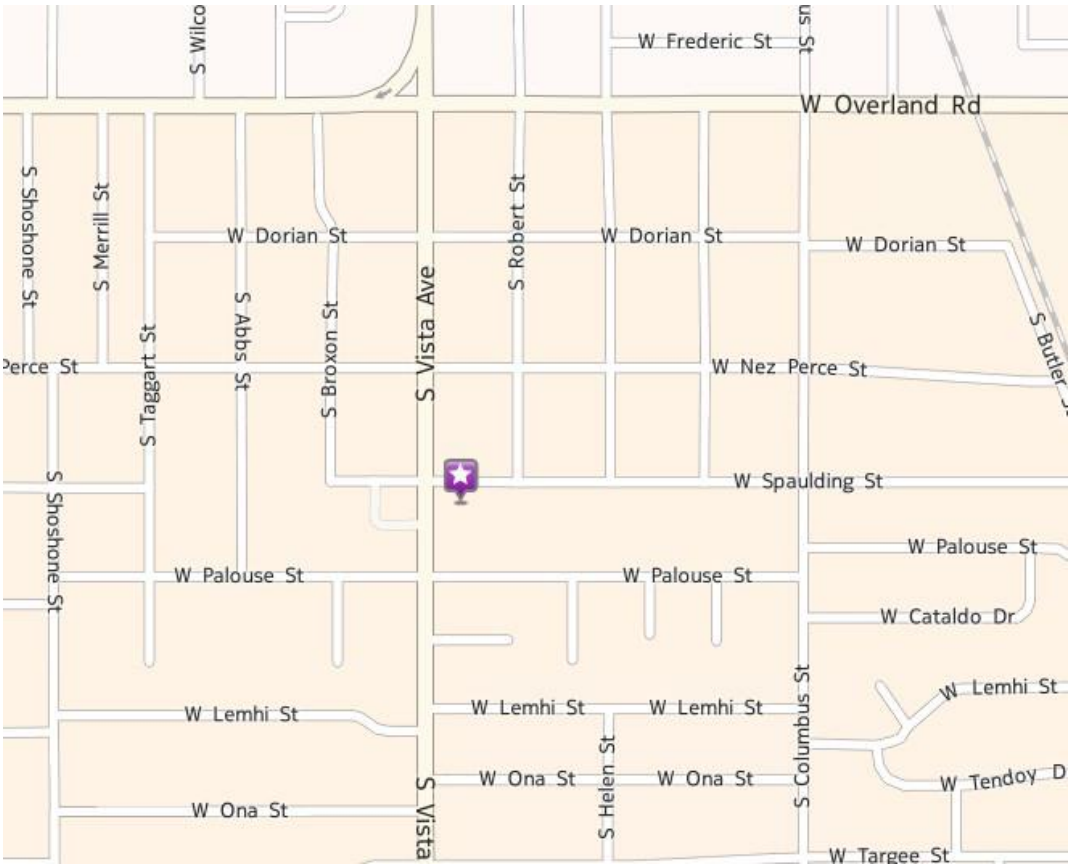
Boise Office

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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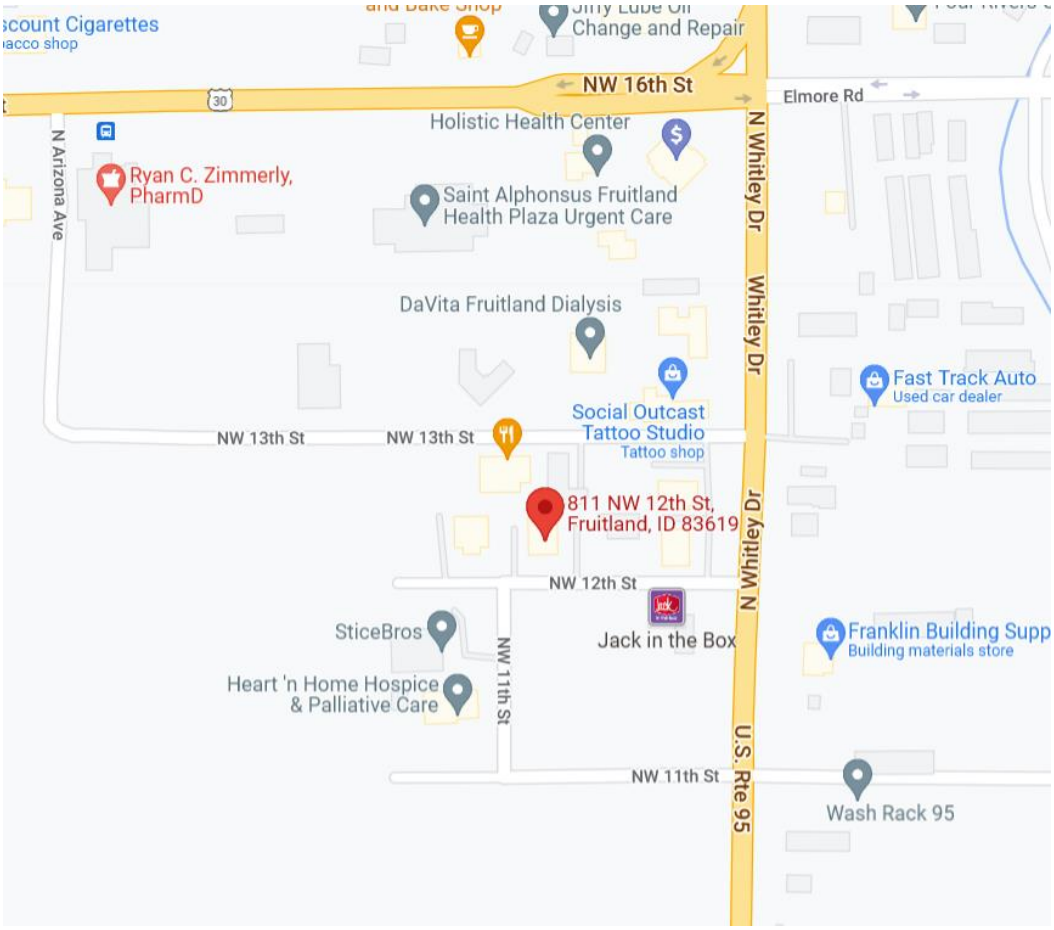
Fruitland Office

From Boise – From I-84 W, take exit 3 to Fruitland. Take a right off the fwy exit to head North on the US 95 for about 3.5 miles. Turn left to head west on 12th St and the office will be on your right.

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. Then follow direction below from Ontario to the office.

From Ontario – Take E Idaho Ave to the US 30 E. Turn right on to N Whitley Dr. Make a right turn on to NW 12th St and the office will be on the right.



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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)

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

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? _____

Flu Vaccination: □ Administered this flu season □Administered previous flu season □ I do not/have not gotten the flu vaccine

(Continued on next page)

Quality Measures (for patients 65 or older)			
Have you received a pneumonia vaccination? □ Yes □ No			
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	**Secondary Insurance**
Insurance Name: _____	Insurance Name: _____
Policy/ID#: _____	Policy/ID#: _____
Group#: _____	Group#: _____
Primary Policy Holders Name: _____	Primary Policy Holders Name: _____
Date of Birth: _____SS#: _____	Date of Birth: _____SS#: _____
Address of Insured: _____	Address of Insured: _____
_____	_____
Relationship to the patient: _____	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: _____

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

FINANCIAL POLICY STATEMENT

Thank you for choosing Idaho Skin Surgery Center, PC for your Dermatology and Skin care needs. Policies listed herein have been approved by the management with the goal of providing you with quality and affordable health care. In order to accomplish this, we need your assistance in reading and understanding our financial responsibility and payment policy.

Payment Responsibility

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While the clinic will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the rates and terms of the clinic in effect at the time of service. ***Copays and Deductible*** are due at the time of service. Payments will be accepted in cash, check, Visa, MasterCard, or Discover. The clinic will make every effort to assist patients in meeting their financial obligations. Financial arrangements for payments must be authorized by the office manager ***prior*** to any procedures or surgeries and will be made at the clinic's discretion based on the amount.

Acceptance of Insurance

We participate in many insurance plans including Medicare. The clinic will submit a bill to the insurance carrier(s) on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient/guarantor of financial responsibility. Because most of the data we have relative to you comes from you and your insurer, please help us maintain accurate records by filling out forms legibly, and letting us know whenever important data changes (like your address, telephone number(s), any changes in your name, your medical insurance, etc.). The clinic will make every effort to verify insurance coverage, deductible, acceptance of payment for services and other limits for the patient as a courtesy.

Proof of Insurance/ID

All patients must complete our patient information form. We must also obtain a copy of your driver's license and current, valid insurance card. If you are unable to present an insurance card at the time of service, or if you are covered by an insurance with which we are not contracted, we require that you pay in full for services in advance.

Know your Benefits

Each and every insurance company, including Medicare, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have relative to your own benefits with them. Many insurance plans have their own specific criteria for which services they will cover and how frequently they will cover them. Consequently, it is impossible to know all of the many different employer group benefits from one employer to the next. Therefore, Idaho Skin Surgery Center, PC cannot be held responsible for informing patients whether a particular service is "covered" or not. However, our staff will make every effort to try to assist you in understanding your health benefits.

Uninsured/Self-Pay Patients

If you are not covered by insurance, our clinic policy requires a deposit of **$250.00** at the time of your first visit. This deposit will be applied to the total cost of your visit. If you need to schedule a surgery, there will be a **$1500.00** deposit due. Please contact the Billing Department to make payment arrangements ***prior*** to your surgery. We will not be able to schedule surgery and/or follow up appointments until the payment arrangements have been made.

Out of Network Patients

If the clinic is not an in-network provider with your insurance company you may still have out of network benefits that would allow you to be seen. In the event that your insurance carrier(s) pay you directly for services performed at Idaho Skin Surgery Center, PC; you are required to turn over the check to our office within 7 days of receipt.

Claims Submission

Our office will submit your claims for the insurance companies we are contracted with and assist you in any way we reasonably can to help you get your claim 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.

(Continued on next page)

Patient Responsibility
If you have a balance **after** your insurance has paid your claim, we will send you a statement and the balance will be due within 30 days of the statement date, unless you made prior payment arrangements with the Billing Department. **If there is a credit of $5.00 or less it will be written off**. Past due accounts which have not contacted our office to set up payment arrangements may be sent to an outside collection agency where you will be responsible for collection and/or legal fees. You will receive a past due letter sent to you by Registered Mail if we have not received payment within 93 days.

Medicare Patients
For the convenience of our Medicare patients and to expedite billing of services to Medicare on their behalf, ISSC will maintain your signature on file.

Minor Patients
The adult accompanying a minor and the parents/legal guardian of the minor are responsible for full payment. 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 an adult/legal guardian, an Authorization for Treatment to Minor form must be filled out and notarized **prior** to the minor being seen for non-emergency treatment. This form can be obtained from our office or website at: www.idahoskinsurgerycenter.com.

Non-Covered/Cosmetic Fees
Your Idaho Skin Surgery Center, PC provider may provide services that may not be covered as a benefit of your specific plan with your insurer. ***Coverage Issues*** can only by 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.

Outside Pathology, Lab Fees
Biopsy, Pathology and Lab samples sent outside of our office are billed separately from your insurance claim.

Returned Checks
There is a **$35.00** fee for returned checks. If your check is returned from the bank, we will no longer be able to accept checks as payments on your account. Future payments ***must*** be made with cash, money order or credit/debit card.

"NO-SHOW" Policy
Any patient that does not show for their scheduled **office visit** appointment and does not call within 24 hours to cancel or to reschedule, will receive a **$25.00** charge. Any patient that does not show for their scheduled **surgery** appointment and does not call within 48 hours to cancel or to reschedule, will receive a **$200.00** charge.

Refund Policy
In the event there is a credit balance, due to an overpayment, we will make every effort to refund the balance within 30 days from the time the credit balance is discovered. Where an economic hardship is involved, we will expedite the refund upon request of the patient or responsible party. If the refund check is lost or misplaced and a stop-payment is required then there will be a **$30.00** fee deducted from the check.

I have read the above Financial Policy Statement and agree to the payment policies and understand my patient responsibilities as confirmed by my signature below.

_____
Patient or Responsible Party Signature

_____
Patient's Printed Name

_____
Responsible Party's Printed Name (if applicable)

_____
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# _____